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PSYCHOTHERAPISTS' EXPERIENCE OF DIFFICULT CLINICAL MOMENTS

A COMPARATIVE STUDY BETWEEN INEXPERIENCED AND EXPERIENCED PSYCHOTHERAPISTS

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PSİKOTERAPİSTLERİN ZOR AN DENEYİMLERİ
DENEYİMSİZ VE DENEYİMLİ PSİKOTERAPİSTLER ARASINDA KARŞILAŞTIRMALI BİR ÇALIŞMA

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Abstract

The purpose of this study was to understand how psychotherapists make sense of and give meaning to their subjective experiences of what they define as a difficult clinical moment, to investigate the effects of these moments on their private and professional life and to compare the findings of experienced and inexperienced psychotherapists to find the similarities and differences between their experiences. By comparing the findings, this study aimed to encourage psychotherapists that are new in this profession to seek help and guidance when they need, help improve their clinical practice, motivate them about being a psychotherapist and help trainers and supervisors to improve psychotherapy training programs and supervisions in a way to provide more support to inexperienced psychotherapists experiencing difficulties. A sample of 4 inexperienced psychotherapists and 4 experienced psychotherapists were interviewed to understand their experiences in difficult clinical moments. As a result of the Interpretive Phenomenological Analysis, 6 superordinate themes and 7 sub-ordinate themes have been found. The themes that show similarities between inexperienced and experienced therapists are: 1. Fear of Boundary Violations, 2. Avoiding Revealing Feelings, 3. Sadness. The themes that show differences between inexperienced and experienced therapists are: 1. Feeling Incompetent, 2. Anger Management, 3. Intolerance to Uncertainty. The results of the study were interpreted and discussed in the light of existing psychoanalytic and existential literature on psychotherapists' experiences in psychotherapy. The meaning of these results and discussions and recommendations for inexperienced psychotherapists, experienced psychotherapists, trainers and supervisors are provided in the implications section. In the last section, the limitations of this study and future research recommendations are given.

Key words: Psychotherapists experiences, difficult clinical moments, psychoanalytic, existential, self disclosure.

Özet

Bu çalışmada, psikoterapistlerin, "zor an" olarak adlandırdıkları öznel klinik deneyimleri nasıl anlamlandırdıklarının anlaşılması hedeflenmiştir. Klinik ortamda yaşanan bu zor anların, özel ve profesyonel hayatlarına nasıl etkileri olduğunun anlaşılması amaçlanmıştır. Bu çalışmada, deneyimsiz ve deneyimli psikoterapistlerin, "zor an" deneyimleri karşılaştırılmıştır. Bu karşılaştırmayla, deneyimsiz psikoterapistlerin bu deneyimler sonucunda yardım almaları konusunda ve psikoterapi mesleğini icra etme konusunda yüreklendirilmesi amaçlanmıştır. Ayrıca, bu çalışmayla, deneyimli psikoterapistlerin, eğitimcilerin ve süpervizörlerin, deneyimsiz terapistlere zor an deneyimleri konusunda daha etkin bir biçimde yardım edebilmesine destek olunması amaçlanmıştır. 4 deneyimsiz psikoterapist ve 4 deneyimli psikoterapistle derinlemesine görüşmeler gerçekleştirilmiştir. Yorumlayıcı Fenomenolojik Analiz yöntemiyle, elde edilen veriler analiz edilmiş, 6 ana tema ve bunlara bağlı 7 alt tema bulunmuştur. Deneyimsiz ve deneyimli terapistler arasında benzerlik gösteren temalar: 1. Sınır aşımı korkusu, 2. Duyguları belli etmekten kaçınma, 3. Üzüntü. Deneyimsiz ve deneyimli terapistler arasında farklılık gösteren temalar: 1. Yetersizlik hisleri, 2. Öfke kontrolü, 3. Belirsizliğe katlanamama. Bu çalışmanın sonuçları, psikoterapistleri deneyimlerine dair psikanalitik ve varoluşçu literatür ışığında anlaşılmış ve tartışılmıştır. Bu bulguların, deneyimsiz psikoterapistler, deneyimli psikoterapistler, eğitimciler ve süpervizörler için anlamları öneriler kısmında sunulmuştur. Son kısımda ise çalışmanın sınırlılıkları ve gelecek çalışmalar için öneriler ele alınmıştır.

Anahtar kelimeler: Psikoterapistlerin deneyimleri, psikoterapideki zor anlar, psikanalitik, varoluşçu, kendini açma.

1. INTRODUCTION

1.1. PURPOSE OF THE STUDY

The purpose of this study was to understand how psychotherapists make sense of and give meaning to their subjective experiences of what they define as a "difficult clinical moment", to investigate how these moments affect their private and professional life and to compare the findings of experienced and inexperienced psychotherapists to find the similarities and differences between their experiences. This study aspired to help psychotherapists, especially inexperienced therapists, understand the meaning of their experiences, encourage them to seek help and guidance when they need, help improve their clinical practice and their motivation about being a psychotherapist. This study also aims to help experienced therapists, trainers and supervisors to improve psychotherapy training programs and supervisions in a way to provide more support to inexperienced psychotherapists experiencing difficulties.

By comparing inexperienced and experienced therapists' subjective experiences and revealing the similarities and differences, this study strives to reveal that no matter how experienced the therapist is, it's normal to experience difficult clinical moments and to get affected by them professionally and personally. In this study, four experienced psychotherapists with an average experience of 10 years and four inexperienced psychotherapist with an average experience of 1 year participated in unstructured interviews. To explore the experiences of the psychotherapists, interpretative phenomenological analysis (IPA) was used.

Inexperienced psychotherapists may get so emotionally hurt that they can lose motivation for their profession (Honda, 2014). However, difficult clinical moments not only experienced by inexperienced therapists. It has been found that these difficult clinical moments are experienced whether the therapist is inexperienced or experienced (Orlinsky & Ronnestad, 2005). Despite the fact that these difficult clinical moments are inevitable for therapists, there is very little training available regarding the therapist's experiences of these difficult moments according to recent

research (Pope et al., 2006). It has also been found that therapists prefer not to talk about their experiences about these difficult moments in supervision sessions because of their concerns of being seen as an inadequate therapist and the non-disclosure of these moments prevents the therapists from benefiting from the supervision (Thériault & Gazzola, 2005). It has been found that therapists tend to talk about these experiences with a supervisor who normalizes these experiences by sharing their own experiences in difficult moments (Knox et al., 2011). Knowing that experienced therapists also experience difficult clinical moments, inexperienced therapist can be motivated for their profession, become more likely to seek help for these feelings they have and try to understand their meaning (Schröder & Davis, 2004).

1.2. PERSONAL BACKGROUND

Relationships have always been hard for me. Being in the presence of the other, being in a close relationship or even a casual conversation with a person was enough for me to experience uneasy feelings about both myself and the relationship. Trusting someone, letting them into my life, feeling safe in a relationship, communicating without feeling anxious were rare experiences for me. But then I chose a profession that is all about relationships. I was very young back then and I didn't think of the consequences of this choice. If I had realized that this profession was all about being in relationships with others, I probably would have given it up with fear back then. I was so interested in psychology. Moreover, I was interested in understanding my own psychology, untying the knots and solving the riddles of my own inner world, discovering my wounds and healing them. I now realize that I chose this profession for the very reason of healing my relational world.

The year 2012 was an important year for me and my career. I started the existential psychotherapy training, got accepted to a master's degree program in psychology, I experienced being a client by beginning my own therapeutic process and I experienced being a therapist. My first experiences of being in the therapy room with a client were horrific. Both as a person in the presence of another person and

a therapist in a relationship with a client, I was experiencing all sorts of feelings. I remember being frozen with fear, with feelings of incompetence, wondering what the client might think of me, both as a therapists and a person. I remember counting the minutes to the end of the session and feeling like the time was not passing. I felt like I got trapped with this fear and pain and that was excruciating. The clients did not have to do or say much to make me feel this way. For me, the difficult clinical moment was the relationship itself.

Even now as a psychotherapist who finished a four year long training on existential psychotherapy, who is completing her second master's program (clinical psychology) and is in the termination process of her own therapeutic process, sometimes I still go to that place where time froze and I got trapped in the excruciating presence of the other. But nowadays it's very rare. Now I know the way out of that feeling. I now have the ability to soothe myself and more importantly, I have the ability to feel safe in a relationship.

Last year during the clinical internship of my master's program, I experienced that it was not just me who is subjected to these kinds of hardships in the therapeutic dyad. My peers from the program were also experiencing several kinds of difficulty experiences in the therapy room and the training that we had was not sufficient to help us deal with them. We had the opportunity to receive supervision from meritorious supervisors, who helped us with these difficulties but sometimes my peers and I shared a feeling of being left alone with our struggle against these difficulties. Moreover, most of my peers were worried about the fact that they were experiencing these difficulties, thinking that it's not normal, it's wrong, it's a deficiency to feel that way. They stated that their motivation towards becoming a therapists decreased over time.

Because of these experiences, I decided to study this topic and compare the difficulty experiences of experienced and inexperienced therapists to show that it's not a deficiency to feel this way. It's normal and it might change in time. With this study I hope to help both myself and inexperienced therapists and I hope to show that it's normal to experience these difficulties in the therapeutic dyad, because it's

a hard profession, where we immerse ourselves in others' wounds and let ourselves be rewounded continuously in this encounter.

Laying out the difficulties I face in relationships and also in the psychotherapy relationship, I believe that this section is important for revealing my assumptions about this study. Being open about my assumptions is crucial for bracketing them as I conduct this study and try to keep my attention to the study's data in an open minded and non-biased way as much as I can, while trying to minimize the effect of my assumptions on the results of the study.

1.3. GAP IN THE RESEARCH AREA

There are studies on countertransference (Gelso & Hayes, 2007), on the classification of difficult moments in therapy (Schröder & Davis, 2004) and the prevalence of the types of difficulties (Orlinsky & Ronnestad, 2005). Also, there are some valuable "memoir" books (Casement, 2002; Kottler, 2003; Kottler and Carlson, 2003) of experienced psychotherapists about their difficulties in this profession, but these books are written in a fiction-like manner. So, although there are quantitative studies and memoir books written by experienced therapists which reflect their own difficulty experiences in psychotherapy, the area of qualitative research on the subjective experiences of the therapists' difficult moments seems to have been disregarded. There is just one study on the meaning of the subjective experience of difficult clinical moments, which investigates the experienced therapists' experiences on difficult clinical moments. (Honda, 2014).

Since there is only one IPA study on this topic, the gap in the research area can also be explained by the lack of phenomenological research in this area.

Existential philosopher Edmund Husserl developed phenomenology as a method for understanding human experiences. Phenomenology is the art of listening to a person's experiences, feelings and reactions while putting aside biases and assumptions. Since then it has been used as an effective research tool to fully understand people's subjective experiences. The aim of the phenomenological

research is to discover and describe the human experience as it is, rather than explain and prove it (Van Deuzen & Adams, 2011).

Differing from Honda's (2014) study, in this study, the subjective difficulty experiences of inexperienced and experienced therapists are to be compared and common themes are aimed to be revealed.

2. LITERATURE REVIEW

Psychotherapists encounter many difficult clinical moments throughout their professional life. A difficult clinical moment can be defined as a moment with the client that causes the psychotherapist to experience distress in or out of a therapy session. The psychotherapist may feel demoralized, inadequate, scared, angry, confused, guilty, ashamed, and helpless and so on. The concept of "difficult clinical moments" is very wide and subjective. Because of this, the therapists who participated in the study were asked to define what a difficult clinical moment for them is. A difficult clinical moment for one therapist, may not be difficult for another therapist. Although the concept "difficult clinical moments" is subjective and vary between therapists, the possible reasons of the emergence of these difficulties and the therapists' experiences of these difficult clinical moments will be reviewed below.

This chapter includes an exploration of the previous studies and theories on the difficult clinical moment's issue. Firstly, the empirical studies about the difficult clinical moments for therapists will be reviewed. Secondly, a theoretical literature on countertransferencial, noncountertransferencial experiences of therapists, empathy, therapeutic impasses, raptures and negative therapeutic responses will be presented.

2.1. PREVIOUS RESEARCH

Psychotherapists encounter many difficult clinical moments throughout their professional life and the unique experiences of the therapist is a very important research area. But somehow this research area has been neglected and in the few studies about the difficulties in therapy, main focus tends towards the pathology of the clients (Rachlin & Lev, 2011; Waska, 2011). In the literature review prior to this study, five studies (Davis et al., 1987; Plutchik, Conte, & Karasu, 1994; Schröder & Davis, 2004; Orlinsky & Rønnestad, 2005; Smith et al., 2007; Honda, 2014) about the difficulties experienced by therapists will be reviewed.

A taxonomy of nine difficult experiences for therapists was developed in a study by Davis, Elliot, Binns, Francis, Kelman and Schröder in 1987, where therapists' difficulties were defined as "experiences that are difficult for the therapist in the therapeutic circumstances:

Incompetent: The therapists who attended the study expressed that they find themselves inadequate in their performance in the therapy room and have narcissistic injuries as a result of the difficult moments with the clients.

Damaging: It has been found that, therapists tend to fear that they are harming their clients and feel guilty. For example, when the client is scared of unbearable feelings and is trying to avoid them, therapists worry about harming the client and feel guilty while suggesting the client gets in touch with the said feelings.

Puzzled: Therapists sometimes feel confused about what should be done in a specific situation and how to respond to the client.

Threatened: Especially with persecutive clients, therapists might feel threatened and try to protect themselves.

Out of rapport: It has been found that, sometimes therapists find it hard to relate with specific clients. Therapists end up feeling distant and aloof with those specific clients.

Personal Issues: Therapists fear that their personal issues or personality dynamic might intrude into the therapeutic relationship.

Painful reality/ethical dilemma: In therapy there are moments where an unavoidable painful reality appears and sometimes the therapist can't decide what to do with this kind of information and feels confused about what would be ethical.

Stuck: Sometimes therapists feel stuck and trapped in specific situations in therapy. They feel like they are going nowhere, not making any progress.

Thwarted: It has been found that, when clients act defensive against the efforts of the therapists, therapists might experience frustration, anger and impatience.

As a limitation in the study by Davis and colleagues (1987), the researchers didn't collect data from a sample from general therapist population and instead participated in the study themselves. Even so, a decent review on this topic has been provided by their study.

In 2004, two of the researchers of this study made a new research grouping therapists' difficulties under three topics:

Transient difficulties: These difficulties are temporary difficulties that therapists experience, which emerge from the therapist's lack of knowledge, skills and experience and can be overcome in time.

Paradigmatic difficulties: These difficulties were defined as lasting ones, like therapist's personal difficulties, conflicts and dynamics.

Situational difficulties: It has been found that there are some situational difficulties caused by external factors and problematic circumstances.

According to Schröder and Davis (2004), as therapists gain experience, a decrease in transient difficulties was observed, while paradigmatic and situational difficulties were not found to be related to therapists' experience. Again as a limitation, researches participated themselves in the study and the experiences of challenging moments haven't been examined.

In 2005, Orlinsky and Ronnestad, published their book which studied the professional development of therapists with the participation of 4,923 therapists from several countries and as a result, difficulties of therapists have been collected under three topics:

Professional self-doubt: It has been found that, in the difficult clinical moments, therapists might experience professional self-doubt, emerging from their lack of confidence, inadequacy, fear of harming the client, confusion about the client's problems, etc...

Frustrating treatment case: Sometimes the difficulties are experienced because of frustrating treatment cases like, feeling angry, powerless and troubled with specific clients or the enduring circumstances that prevents improvement in the client's life.

Negative personal reaction: It has been found that, sometimes therapists find it hard to like a client, feel unable to relate with the client and have empathy.

Even though there are few limitations on this research, the lived experiences of challenging moments haven't been examined.

In 2007, Smith and colleagues did a research on the challenging moments in therapy with both inexperienced and experienced therapists and collected the reactions of the therapists under three topics:

Traumatic: As a result of the study, it has been found that, the traumatic experiences of clients that unveil in therapy creates difficulties for the therapists. Therapist end up feeling anxious, shocked, overwhelmed, and experience psychosomatic symptoms after being confronted with these traumatic situations.

Interactional: Sometimes the difficulty in the therapeutic process appears to be an interactional difficulty with verbally or nonverbally provoking or manipulating clients, which makes therapists feel helpless or make more than usual emotional investment to the process.

Existential: It has been found that, when the client's circumstances in life are very difficult handle, therapists feel so much responsibility about the client and it becomes a rumination for the therapist.

It has been found that all therapists experience difficulties no matter what their experience level is. However, the lived experiences of challenging moments have once again been disregarded. In Honda's research (2014) on seasoned therapists' experiences of difficult clinical moments, a thematic analysis has been made with the help of which the lived experiences of experienced therapists were explored. Six themes have been found:

Feeling Fear: As a result of this study, it has been found that, therapist feel anxious, afraid, frightened, panicked, nervous, horrified, traumatized etc.-and experience physical symptoms in difficult clinical moments.

Feeling Inadequate: It has been found that, in difficult clinical moments, therapists reported feeling a lack of confidence and experiencing feelings of uselessness, incompetence, shame and insecurity.

Feeling Anger: Therapists reported feeling angry, frustrated, furious, hateful, full of rage, etc. in difficult clinical moments, as a result of this study.

Feeling Confused: It has been found that, therapists sometimes feel so confused in difficult clinical moments that they can't decide what to do.

Feeling an Urge to Hide Feelings: Therapists reported in this study that they sometimes want to hide their feelings from the clients in the difficult clinical moments.

Feeling an Urge to Terminate: Lastly, in this study, it has been found that, therapist don't want to work with all their clients; in some difficult clinical moments they wish to terminate their clients or wish they would drop out.

Among the few studies on therapists' difficulties, there is one study (Honda, 2014) that explored the experiences of therapists in difficult moments phenomenologically.

2.2. COUNTERTRANSFERENCE

In the first part of this chapter, countertransference will be reviewed from the theoretical perspectives of psychoanalysis and in the second part, it will be reviewed from theoretical perspectives of existential psychotherapy.

According to Gelso and Hayes (2007), countertransference consists of therapists' internal reactions (emotions, thoughts, feelings) and external reactions (verbal or nonverbal reactions) in the therapeutic process. Feelings of the therapist, like sadness, fear, anger, disappointment, incompetence, boredom and guilt as well as the therapist's personal difficulties and vulnerabilities co-created by the therapist-client relationship can be regarded as countertransferencial feelings.

2.2.1. Countertransference in the psychoanalytic view

2.2.1.1. Classical psychoanalytic theory

In his famous case Anna O., Joseph Breuer could not handle the guilt that he felt, which was caused by his reaction to the patient's unconscious sexual desires and terminated the treatment because of this difficult experience (Blum & Goodman, 1995). Being inspired by his mentor's reaction, Freud came up with a phenomena called countertransference. He theorized that "countertransference" is the

unconscious feelings that are evoked by patients that should be identified and obviated by the analysts (Freud, 1910).

It's surprising that Freud remarked on countertransference only a few times after giving this phenomenon significance as he expressed above. The phenomena of countertransference created a paradox for professionals for being both a way to understand patients and something that should be eliminated (Gelso & Hayes, 2007).

2.2.1.2. Ego psychology theory

Ego psychologists' stance was similar to Freud's ideas on countertransference. They believed that countertransferencial reactions emerge from the therapist's unconscious problems and they affect the therapist's empathic attitude towards the patients (Gelso & Hayes, 2007).

Starting from 1950's, the attitude against countertransference as a conflict that should be ruled out has changed into it being regarded as an important part of the therapeutic process, which could be both beneficial and inhibiting (Gelso & Hayes, 1998). The understanding of countertransference has changed into being an important source about the patient, therapist, therapeutic process and the therapeutic relationship (Gabbard, 2001).

Relevant with the up and coming self-psychology point of view, Sullivan (1954) states that therapists are not just spectators of the patients, they are the observing participants of the therapeutic dyad.

2.2.1.3. Self-psychology theory

Self-psychology theorists observed the countertransference from an intersubjective stance (Stolorow, 1991). Intersubjectivity in the therapeutic process is defined as *"the field created by the interplay between the differently organized subjective worlds of patient and therapist"* (Trop & Stolorow, 1997, p. 282). From this point of view, it can be said that, the therapeutic process is the meeting of subjective

worlds of both participants of the therapy, namely the therapist and the patient, and the reactions in this process can be apprehended by examining the both subjectivities and their relationship (Gelso & Hayes, 2007).

2.2.1.4. Object relations theory

Relational stance of countertransference continued with the object relations theorists (Aron, 1991; J. R. Greenberg & Mitchell, 1983; Mitchell, 1988). It's emphasized that the countertransference is co-constructed by the reaction between patients (with their needs, dynamics and transference) and therapists. Despite this stance, Klein (1946) argued that the therapists' countertransference emerges mainly from the patients' dynamics. Klein introduced the term *projective identification*, according to which, patients make their therapists feel a certain way with their actions, in an effort to get a certain reaction from the therapists that the patients couldn't tolerate to experience themselves. But this emphasis gives too much burden to patients about countertransference (Ogden, 1994). Even if this definition can be considered right in some aspects, therapists should be in a position where they understand their feelings and take responsibility for their countertransferencial reactions (Eagle, 2000) and all the responsibility of countertransference shouldn't be burdened on the patients (Spillius, 1992).

2.2.1.5. Contemporary thoughts

According to Gelso and Hayes (2007), the difficulties that therapists face are always caused by countertransferencial reactions. On the other hand, therapists could have a tendency of not taking responsibility for their feelings and reactions. This tendency usually comes from the traditional thoughts and teachings of psychoanalytic theory that advices the therapists to remain neutral in the therapy room.

Contemporary thought on psychoanalytic theory embraced the two-person psychology instead of the one-person psychology. On the positive side, two-person

psychology recognizes the therapists' unconscious contribution as a participant of the therapeutic process, but on the downside, the followers of two-person psychology also acknowledge *projective identification*, which undermines the responsibility of therapists' feelings and reactions towards the patients.
Maroda (1991) suggested that, as an extreme event, therapists sometimes use *repetition compulsion* in pursuit of resolving early conflicts in their lives (like separation-individuation issues) and this creates a situation called "countertransference dominance" (Gelso & Hayes, 2007).

2.2.2. Countertransference in the existential view

2.2.2.1. A real relationship

According to Cohn's book *Existential Thought and Therapeutic Practice* (1997), in several views of countertransference, the realness of the relationship between the therapist and the client is a neglected phenomenon. But according to the existential point of view, the relationship between the therapist and the client is as real as any other relationship, because when two people are involved with each other, this creates a relatedness between those people and it becomes a relationship. At that point, it doesn't matter under what circumstances this relationship took place. In a phenomenological point of view, there is no difference between countertransferencial experiences and the experiences people have in relationships. According to Van Deurzen (2010), therapists' experiences, feelings and involvement to their clients is often seen as problematical, especially in the classical view of psychoanalysis. But these experiences shouldn't be neglected, because they contain valuable information about how the client feels, the client's world view and stance in the relationships, no matter which orientation a therapist works with. When two human beings meet and relate with each other, an emergence of some dynamics between them is inevitable and the relationship in therapy can't be excluded from this fact. Van Deurzen (2010), called the therapist's experience of

the therapeutic process and the relationship with the client *"the therapist bias"* as an alternative to countertransference.

2.2.2.2. Therapist bias

According to Van Deuzen (2010), in every relationship, including the relationship in therapy, each person sees the other from his/her point of view and his/her own biases. So, in the existential point of view, instead of using the term countertransference, which suggests that the therapeutic relationship distinguishes from other relationships, it's more appropriate to use the term *therapist bias,* as it gives a more basic concept of a therapist experiences as a human being in the relationship. A person's point of view is biased naturally, so the emergence of the therapist bias shouldn't be pathologised. Because of this natural bias, it's impossible for a therapist's stance to be neutral. Countertransference harbors so many questionable implications that it might create a mental weight that is hard to carry for therapists. Remaining in a phenomenological stance, therapists can be aware of their biases about clients and by the help of this awareness, they can differentiate the biases that create misinterpretations.

The aspects of the therapist bias in the relationship with their clients can be examined as follows:

Therapist's attitude: Every person is unique and each person experiences the world around them differently, due to their own uniqueness. This applies to therapists too. They bring their own unique point of view to the relationship with client. This bias is called therapist's attitude. The therapists' personality, the experiences that they have and haven't had establishes this attitude. People usually have the misbelief that when other people come across with the same experiences as others, they react the same way.

As therapists' experiences shape their biases and attitudes, the same principle is valid also for clients. Clients have an opportunity to understand, change and revise their attitudes into new insights about themselves, their way of experiencing the

world and the others, as a contribution of therapy. Likewise, therapists have the same opportunity of reshaping their attitudes as they meet new clients. A good therapist should have an open and flexible understanding of his/her attitudes, reshape them, accept his/her weaknesses and strengths and broaden their world view. (Van Deurzen, 2010)

Therapist's orientation: Theoretical orientation also creates a therapist bias. Therapists often choose to work with a theoretical orientation that serves the best help to their own struggles in life and complementary to their own attitude. When therapists are working with a certain orientation, it's inevitable that they experience the therapeutic relationship and process through the perspective of their own therapeutic orientation and sometimes this might cloud the therapists' judgement and prevent them from understanding the clients in every aspect of their life (Van Deurzen, 2010).

Therapist's state of mind: Therapist's state of mind is another factor that creates a therapist bias. Simply put, therapist's state of mind is the therapists' feelings and reactions, which are influenced by the immediate experiences in their own life. It's also influenced by the therapists' attitude and theoretical orientation that they chose to work with. In the therapeutic process, therapists' perspective might change depending on their state of mind, which influences one's point of view of the world. So, it would be healthy for the therapeutic relationship if therapists frequently looked inside themselves and reviewed their state of mind (Van Deurzen, 2010).

Therapist's reactions: Therapist's reaction is the instant reaction of therapists towards specific clients, which is influenced by the client's characteristics or the therapist's own attitudes, orientations and state of mind. Each client evokes different reactions in therapists, because of the uniqueness of both parts in the relationship. It's important for the therapists to identify and understand these reactions, so they both understand their clients and themselves. A crucial part of this is to recognize the source of these reactions, whether it rooted from the client's characteristics or the therapist's own attitude or both (Van Deurzen, 2010).

2.3. THERAPISTS' NONCOUNTERTRANSFERENCIAL EXPERIENCES

Therapists' experiential world doesn't only consist of countertransference. A part of therapists' inner experiences and reactions are noncountertransferencial. Some of these feelings and experiences originate from the therapist's subjectivity as a human being interacting with another human being. The difference between therapists' noncountertransferencial feelings and countertransference is, the noncountertransferencial feelings do not usually create inner conflicts for the therapists. In a session, therapists might feel all sorts of feelings that are not related with their inner conflicts. For example, if a patient comes to the session with a gun and threatens the therapists, the therapist's feelings of fear would be a natural response to this situation. This natural response resembles the objective countertransference referred by Winnicott (1965) as mentioned in the previous section (Gelso & Hayes, 2007).

2.3.1. Therapists' inner experiences through the perspective of psychoanalytic view

Psychoanalytic theory is divided into four clusters by Pine (1990) as: drive psychology, ego psychology, object relations psychology and self-psychology. These clusters can be grouped in two as one-person (drive and ego) and two-person (object relations and self) theories investigating the therapists' inner world. The perspective on the therapists' inner world has changed through the years in the psychoanalytic view. Freud's (1912) stance on the therapists' inner world was that he recommended his colleagues to put aside all of their feelings and sympathy because they might cloud their skills on treating their patients.

The stance on therapists' inner world became flexible over the years and the therapists' experiences started taken into consideration. Crowley (1950) in his paper, *Human Reactions of Analysts to Patients,* stated that there could be feelings that analysts experience that are noncountertransferencial and these feelings are ignored in the literature of psychoanalysis. Crowley stated that these feelings are

very important, they could make significant contribution to the analytical process and without these feelings and reactions the analytic process is *"bound to be mediocre"* (Crowley, 1950, p.87).

According to interpersonal and relational approaches therapists'/analysts' feelings, experiences and reactions have a fundamental significance in understanding and treating the patients. According to Thompson (1956), therapists should have an understanding of patients' inner worlds, not only using their intellect and knowledge, but also with the help of their own inner worlds.

According to Mitchell and Aron (1999), the client's materials clarifies whereas the therapist's inner world, feelings and reactions emerge in the togetherness of the therapeutic dyad (the two-person conception). On the therapists' inner world, Renik (1993) states:

> *"It seems to me pointless to ask an analyst to set aside personal values and views of reality when listening or interpreting. Everything an analyst does in the analytic situation is based upon his or her personal psychology. This limitation cannot be reduced, let alone done away with; we have only the choice of admitting it or denying it" (p.559).*

In the light of Renik's words, therapists' inner world experiences, feelings and reactions shouldn't be ignored, because they are an essential part of the therapeutic process, Everything that takes place in the therapeutic process consists of the therapist's subjectivity and the client's offerings blended with it.

2.3.2 Empathy

2.3.2.1. Empathic attunement and authentic engagement

In her book *Modes of Therapeutic Action,* Martha Stark (2000), divided psychoanalytic approach into three models:

- Model 1; the drive-conflict model represents the classical psychoanalytic theory that consists of Freud's drive theory and ego psychology. One person psychology.
- Model 2; the developmental arrest model represents the objects relations and self-psychology theories. One and a half person psychology.
- Model 3; the relational conflict model represents relational and intersubjective psychoanalysis theories. Two person psychology.

According to Stark (2000), in the model 2 therapeutic dyad, when therapists engage with clients, therapists decenter from their inner world experiences and start experiencing the client's inner world as their own inner world. This approach is called empathic attunement. On the other hand, in the model 3 therapeutic dyad, when therapists engage with clients, therapists don't decenter from their inner world experiences; they continue experiencing their inner world while letting the client's inner world enter their inner world and experience their inner world as their own inner world. This approach is called authentic engagement.

2.3.2.2. Empathy and intersubjectivity

According to Heinz Kohut (1971), as mentioned above, empathy consists of the therapists' decentering from their inner world experiences and immersing in the clients' inner world experiences. Empathy is a fundamental part of a therapeutic process and clients feel understood and accepted with the existence of empathy. The introjection of the client's inner world is a necessity for a good therapeutic process and it's only possible with empathy. (Sedgwick, 2001)

Robert Stolorow (1978), at first accepted this approach to empathic attunement, but then, he started to question if this approach was limiting the intersubjective experience. He argued that in the therapeutic dyad, therapists can't just remain as empathic self-objects, they are a part of this relationship with their own subjectivity (Stolorow, 1988).

According to Sedgwick (2001), sometimes it becomes difficult for a therapist to exist in the empathic togetherness of the therapeutic relationship and it can be regarded as a sign of countertransferencial feelings.

2.3.3. The Wounded Healer

According to Carl Jung (1954), in the therapeutic dyad, two people combine with each other, like chemicals in a test tube and each member experiences a transformation as a result of the treatment. The therapist in this dyad, remains in a "vulnerable" position. The origin of the word "vulnerable" is *vulnero,* a Latin word that means "wound, wounded". So according to Jung, the therapist might become wounded or rewounded as a result of the therapeutic process. Gaist's (2010) statement about this phenomenon is as *"...sacrifice is involved, whereby the healer must pay the price of getting in touch with inner trauma for the sake of becoming an effective helper" (p. 284).*

According to Jung there are archetypes which he describes as *"...patterns of psychic perception and understanding common to all human beings as members of the human race" (Hopcke, 1999, p.13).*

Some of these archetypes are "Hero", "Wise Old Man", "the Trickster", "the Divine Child" and "the Wounded Healer".

The archetype Wounded Healer originates from the Greek myth about a centaur (half man, half horse) called Chiron, who got wounded by Heracles' arrow. Chiron didn't die from his wounds and instead, he became a healer, because of the pain of his wounds. Chiron's woundedness is what makes him able to heal others (Whan, 1987).

According to Jung, this myth represents the therapist in the therapeutic process as the wounded healer. Therapists are able to heal others by becoming aware of their own wounds (Sedgwick, 2001). Also, the process of healing the wounds, therapists' immersion into the clients' inner wounds, makes the therapists experience their own wounds again and become rewounded. This phenomenon represents the

countertransferencial or noncountertransferencial experiences, difficult feelings and emotions of the therapists (Viado, 2015).

2.4. THERAPEUTIC IMPASSES AND RAPTURE

2.4.1. Therapeutic Impasses

Sometimes the therapeutic relationship gets to a stage where both sides of the therapeutic relationship, both the client and the therapist feel like the therapeutic process comes to a point of no return; it becomes so complicated and challenging that it creates an impasse, a deadlock (Weiner, 1974; Atwood et al.,1989). Weiner (1974) states that therapeutic impasses create difficult moments for therapists and as a result of an impasse, the therapist might experience feelings like anger, incompetence, frustration and disappointment. According to Atwood and colleagues (1989), the reason for therapeutic impasses might be the client's pathology, which creates an obstacle for the client to benefit from the therapeutic process; the therapist not meeting the client's expectations, because of factors like therapeutic orientation, experience or personality type; the lack of therapeutic alliance, the client's transference and the therapist's countertransference or the therapist might simply fail to understand the client.

According to Mitchell (1997), the therapeutic impasses should be seen as a coconstructed conception and might provide a unique pathway, a royal road, for the therapeutic dyad. These impasses grant therapists an opportunity to maintain a self-awareness, change their stance in the therapeutic dyad, take a step out of the rigid relational patterns of the client and this makes the client's self-experience change in a good way (Goldberg, 2000).

In a research study, Hill (1996) found that therapists feel frustration, anger and hurt as a result of the therapeutic impasses. Although therapists experience these feelings as a result of therapeutic impasses, in another study, it has been found that regardless of their feelings, therapists stay helpfully present in the therapeutic relationship (Moltu et al., 2010). In another research, it has been found that, while

therapists are going through therapeutic impasses, the need to share these impasses with a colleague emerges to decrease the tension, to gain a different conceptualization and to maintain a supportive witness (Moltu and Binder, 2011).

2.4.2. Therapeutic Rupture

The ruptures in the therapeutic relationship can be experienced as a difficult moment or not. It depends on the therapist's subjectivity. Relationships are encounters of two people coming together. There is no exception for the therapeutic relationship on this matter. Relationships requires negotiations and sometimes moments of impasse and ruptures are inevitable. (Safran et al., 2009).

According to Hegel, human beings experiencing themselves as subjects requires experiencing others as separate subjects, but seeing others as a separate subject creates a fear of losing our self-sufficiency, so people tend to control others to reduce this fear. This creates a paradox, because controlling others destroys the subjectivity of the others and destroys their own subjectivity, own sense of self (Safran & Muran, 2000).

According to Jessica Benjamin (1990), negotiations emerge as a result of ruptures in the therapeutic dyad, and with the help of these negotiations, the client's capacity of seeing the other as not an object, but as a subject and negotiating between their needs and the need of others without jeopardizing the need of their selves and others might be possible. Benjamin calls this phenomena as the intersubjectivity capacity and it's a necessity for the development of intimacy and authentic relatedness (Benjamin, 1990).

2.5. NEGATIVE THERAPEUTIC REACTION

Sometimes, some clients don't benefit from the therapy as the others. According to Freud, some patients can get worse in the psychoanalytic process and he named this phenomenon as "*negative therapeutic reaction"* (Freud, 1961). Freud states that some patients with oedipal issues have a masochistic need to feel worse because of

the guilt that emerges from their sexual and aggressive desires (as cited in Mitchell & Black, 1995).

Karen Horney (1936), grants Freud in this matter and adds that, due to the competitiveness provided from the culture, patients might sabotage the therapeutic process in order to make the analyst feel unsuccessful. Also, healing and feeling better is dangerous because it emerges rage and envy in others. So, remaining sick is safer.

According to Klein, the negative therapeutic reaction does not emerge from oedipal guilt, it emerges from envy. Klein theorizes that, the baby depends on the mother's good breast to live, but the good breast is not always ready to gratify the baby's needs, so the baby develops aggression towards the breast. These feelings of greed, aggression and destruction makes the baby feel guilty and worthless. According to Klein, taking help from another, an analyst creates a reenactment of the developmental phase that they got stuck and like trying to destroy the good breast, they sabotage the analytic process (as cited in Mitchell & Black, 1995).

According to Faye Newsome (2004), some clients might have a secondary gain from remaining in their old self and they resist the change, because they might be getting a gratification which makes it worth to stay in the old conflicted self.

Geoff Goodman (2005) states that, although the clients experiencing negative therapeutic reaction are very common, they only create a difficulty for inexperienced therapists who feel incompetent.

3. METHODOLOGY

3.1. PARTICIPANTS

The psychotherapists that volunteered for this study was selected to maintain a homogeneous sample, which is coherent to the criteria of Smith et al. (2009). The theoretical orientation of all of the psychotherapists that volunteered to participate in this study was psychodynamic psychotherapy. The participants were all from a similar educational background, a similar sociocultural and socioeconomic background. Also, all of the participants were living and working in Istanbul.

In this study, the participants were divided into two groups: four inexperienced psychotherapists and four experienced psychotherapists. The criteria of participation for the first group, the inexperienced psychotherapists, was being a psychotherapist with 6 months to 2 years of experience, with active clinical experience and training or having been graduated from a clinical psychology graduate program which includes psychotherapy training and supervision. The criteria of participation for the second group, the experienced psychotherapists, was being a psychotherapist with 8+ years of active clinical experience and having graduated from a clinical psychology graduate program which includes psychotherapy training and supervision.

A total of eight participants were interviewed for this study. Inexperienced psychotherapist participants were named: Inexp1, Inexp2, Inexp3, and Inexp4. Experienced psychotherapist participants were named: Exp1, Exp2, Exp3, and Exp4.

Inexp1 is a 24 year old woman, currently training in a clinical psychology graduate program, who has 1 year of active clinical experience. Inexp2 is a 26 year old woman, who graduated from a clinical psychology graduate program and has 2 years of active clinical experience. Inexp3 is a 23 year old woman, currently training in a clinical psychology graduate program, who has 8 months of active clinical experience. Inexp4 is a 33 year old woman, currently training in a clinical psychology graduate program, who has 2 years of active clinical experience. Exp1

is a 34 year old woman, who graduated from a clinical psychology graduate program and has 8 years of active clinical experience. Exp2 is a 35 year old woman, who graduated from a clinical psychology graduate program and has 10 years of active clinical experience. Exp3 is a 39 year old woman, who graduated from a clinical psychology graduate program and has 13 years of active clinical experience. Exp4 is a 34 year old woman, who graduated from a clinical psychology graduate program and has 10 years of active clinical experience.

Table 1. Information of the Participants

Participant	Sex	Age	Years of Clinical experience
Inexp1	F	24	1
Inexp2	F	26	2
Inexp3	F	23	8 months
Inexp4	F	33	2
Exp1	F	34	8
Exp2	F	35	10
Exp3	F	39	13
Exp4	F	34	10

3.2. PROCEDURE

The participants were recruited by the snowball method. After the approval of the Ethics Committee for Social Sciences at the Istanbul Bilgi University, the information about the study was announced by the primary investigator (PI) via the contacts of the colleagues and peers of the PI and more potential participants were

recruited.. Then the potential participants were approached by the PI and those who volunteered to participate in the study were informed about the study's purpose, procedure and confidentiality.

Before starting the interviews, a consent form was given to participants, which explains study's purpose, procedures, confidentiality, risks and benefits. The consent form was signed by the participants who were willing to proceed. The interviews lasted 45 minutes to 1 hour. All interviews were done in Turkish. The audio of the interviews were recorded and transcribed by the PI.

3.3. DATA ANALYSIS

This study's purpose is to fully understand the meaning of therapists' subjective experiences of difficult clinical moments while staying true to its essence, so the most convenient method for this study would be phenomenological analysis.

Interpretative Phenomenological Analysis (IPA; Smith & Osborn, 2008) was used to deeply understand meaning of the subjective experiences of difficult clinical moments for both inexperienced and experienced psychotherapists in a phenomenological manner. The recorded audios of the interviews were listened and transcribed to Microsoft Word program by the PI. The transcriptions of the interviews were read and re-read before coding. The interviews were read line by line and initial notes were taken. The initial notes are what stands out in the first place from the data in the basis of experiences, feelings and difficulties. In the data analysis process, a three column system was used. In this system middle column is for the transcript of the data and right column is for the initial notes. After the initial notes, the matters that seems important were extracted and the emergent themes for each participant were written on the left column. Then a list of emergent themes was prepared in the Microsoft Excel program and the emergent themes were clustered into larger themes. Since this study is a comparison of the experiences of the therapists, two categories were prepared as similarities and differences. Lastly, the larger themes that are related to each categories were grouped and created the superordinate themes. The data of this study and the superordinate themes for each

category were discussed with the advisor of this study, who is an experienced psychotherapist.

3.4. VALIDITY

This study is a qualitative study, performed with the IPA method and has no claim of making a statement about the general psychotherapist population; its purpose was to make a phenomenological analysis of the meaning of the difficulty experiences. So, even though the external validity is an unrelated issue in this study, the internal validity is important.

In terms of testing the validity of a study, the four criteria of validity that Yardley (2000) introduced was found helpful:

First criterion of validity is sensitivity to context (Yardley, 2000). In terms of this criteria, the theoretical, sociocultural, personal and ethical backgrounds of the participants was taken into account. In the theoretical context, the literature about therapeutic relationship and the experiences of the psychotherapists were reviewed. The participants of this study are clinical psychologists, with similar educational backgrounds, living and working in Istanbul. So the therapeutic and sociocultural factors were taken into consideration. The participants discussed their training and sociocultural backgrounds in the interviews. The ethical issues of the study were discussed with the advisor of the study and the data collection procedure was started after the approval of the Ethics Committee for Social Sciences at the Istanbul Bilgi University.

Second criterion of validity is commitment and rigour (Yardley, 2000). Even though it was PI's first experience of an IPA study, the study was conducted as studious as possible. The PI was trained on how to conduct IPA studies and took research supervision from her advisor. The relevant literature was reviewed thoroughly and the data of the study was used in the best possible way.

Third criterion of validity is coherence and transparency (Yardley, 2000). In terms of this criterion, the PI was endeavored to make clear and transparent descriptions in the literature review, method, results and discussion sections.

Fourth and last criterion of validity is impact and importance (Yardley, 2000). In the implications and recommendations sections, the implications that arised as a result of this study were considered in order to manifest the the impact and importance of this study.

4. RESULTS

According to the analysis of the interviews, the superordinate themes that show similarities and differences between experienced and inexperienced psychotherapists' experiences of difficult clinical moments are shown in the table below:

Table 2. Superordinate Themes

Themes showing similarities	Themes showing differences
1. Fear of boundary violations	1. Feeling Incompetent
2. Avoiding revealing feelings	2. Anger
3. Sadness	3. Intolerance to uncertainty

Some main themes in each group have some subordinate themes that can be seen in the table below:

Table 3. Subordinate themes

Sub-themes showing similarities	Sub-themes showing differences
Fear of boundary violations	Inadequacy
1. Anxiety about keeping the therapeutic frame	1. From first session anxiety to a flexible flow
2. Anxiety about disappearance of the boundaries	2. From the dreadful drop outs, to accepting the client's capacity of being held
3. Fear of physical boundary violations	3. From being a mother that starves her child to embracing limits
4. Emergence of psychosomatic symptoms	

4.1. THEMES SHOWING SIMILARITIES BETWEEN EXPERIENCED AND INEXPERIENCED PSYCHOTHERAPISTS

Below there are main themes that were found to be similar between experienced and inexperienced psychotherapists when it comes to their experiences of difficult clinical moments. For a theme to be common between each groups of participants, it had to be narrated by at least two of the four participants in each group.

4.1.1. Fear of Boundary Violations

All participants of this study stated that they experience fear of boundary violations in the difficult moments in psychotherapy.

4.1.1.1. Anxiety about keeping the therapeutic frame

There are several situations that evoke feelings of fear during psychotherapy. One of them is about keeping the therapeutic frame. Both experienced and inexperienced psychotherapist mentioned that they feel fearful and anxious towards patients that are aggressive towards the therapeutic frame.
For instance, Exp1, who was one of the experienced psychotherapists, was working with a client who was aggressive towards the therapeutic frame and who threatened to make a complaint about her:

> "I felt that I was in danger. The client was trying to circumvent me. It was like the client was trying to restrict my range of motion. It was like I was in danger, I felt terrified. I tried to keep the therapeutic frame but then I had a feeling like it's harming my client, keeping the frame is harmful and the client will make a complaint about it and put me in danger. Like this client, the clients that are aggressive towards the therapeutic frame always terrify me. It's a blurry area for me, remaining there. For example, when a client calls me in inappropriate ways or texts me on WhatsApp…in other words, stepping

outside of the therapy room terrifies me. I have to keep the therapeutic frame, for me and my client's best interest. I'm scared of stepping outside of the frame, failing to keep it and letting a client manipulate me and not realizing it." (exp1)

One of the participants who is an inexperienced psychotherapist, Inexp1, also shares this anxiety about keeping the frame and violating the boundaries herself:

"The only solid thing in psychotherapy I'm holding on to is the therapeutic frame and recently I became very obsessive about it. I'm terrified of the things that may occur in the therapy room if I don't hold on to it discretely. Every kind of boundary violation comes to my mind. The thing I fear the most is that I unintentionally make a boundary violation. What if I fail to realize that I made a boundary violation? Because it's normal and expected that a client violates the boundaries, the client desires the boundaries to disappear. As a client in my psychotherapy process, I experienced it. It's me, the therapist that has to keep the frame discretely and I'm scared of failing to hold it. For example, I don't shake hands with clients. I'm afraid of it. It's a simple thing, many therapists think its ok to shake hands. Sometimes in sessions I make jokes when appropriate. At first I found it harmless, moreover a good thing for maintaining the therapeutic relationship. But now I constantly think about every word I say, worrying that it might be understood wrongly and cause a boundary violation. I feel terrified. Probably it's about my own desires. What happens inside the room stays inside the room. We, as therapists, determine the therapeutic frame. Therapist is ethically responsible of the clients. So, it's very scary." (inexp1)

4.1.1.2. Anxiety about disappearance of the boundaries

Some participants state that they fear the disappearance of the boundaries between them. Sometimes they identify with the client and fear that their inner world, their dynamics, will interfere with the clients and damage the therapeutic relationship.

Exp4 narrates this fear:

> "I'm scared of reflecting my dynamics, my patterns to the client. I fear that the boundaries will become permeable. Like every person in the world, I have personal issues too but I fear that these issues, my inner world will plague the sessions, blend with client's inner world." (exp4)

When Exp3 started doing psychotherapy in her native language, she states that she felt traumatized:

> "I haven't been speaking my native language since I came here when I was 7 years old. Until the age of 7, my inner world, my personality was built on the foundation of my native language. When I started a therapeutic process with a client in my native language, I realized that I feel the emotions more intensely than when I work in Turkish. This was so hard for me. It revealed so many raw and unnamed emotions inside of me. I felt traumatized, I was scared a lot. It was like boundaries disappeared. Our inner worlds got blended. The feeling was so heavy for me. I would say that it was a situation beyond counter transference." (exp3)

Inexp1, tells that she experiences dissociations with a client and fears that their inner worlds are blending with each other:

> "These dissociative state I found myself in terrified me. The feeling of disappearance and being groundless I experience in sessions was terrifying.

> It was like I'm not myself anymore and I disappeared into my client's inner world. It was a point where I couldn't feel my personal boundaries, I couldn't say where I end and my client begins. It was like we merged and I was lost in the dark. It was so scary seeing that the boundaries disappear between us. What if my client occupies my inner world? What if I occupy my client's inner world? I know this fear comes from an archaic place inside of me, it sounds like psychotic state." (inexp1)

Likewise, Inexp4 feared that her feelings would interfere with a client's therapeutic process, when the client made an offensive comment about a personal matter of hers:

> "The most difficult moment in therapy for me was the moment that a client of mine made an offensive comment about me. It was a personal and traumatic matter for me and facing it was terrifying. It was like my past haunted me at that point. It was like my inner world was uncloaked and the client infiltrated inside of me" (inexp4)

4.1.1.3. Fear of physical boundary violations

One of the difficult moments that participants state having a fear response towards are situations that threaten the therapists' physical safety.
One of our experienced psychotherapist participants, Exp2 states that she was frozen with fear when a client threatened her life:

> "I remember trying to remain with the client's feelings, but inside my blood pressure hit the ceiling. At that moment, I felt like ethics, boundaries disappeared. I was scared for my life. If we have three responses to threats as fight, flight and freeze, I generally freeze in threatening moments. I play dead to not be dead. Because I know that every word that comes from my mouth at that point will make the situation more dangerous for me. I remember

sitting in the room with the client quietly. I felt so helpless and scared." (exp2)

Inexp2, one of the inexperienced psychotherapist participants, describes having an unrealistic fear of physical threat and feeling traumatized while working with abused children:

"My internship was in an institution for abused children. When I first visited it, I felt so exposed, defenseless, I was scared of the children. They were all abused children, taken from their families by the government. There was a heavy feeling in the air that made me shiver with fear. I felt traumatized. I felt that heavy feeling crushing me. I felt traumatized. I feared that the children would harm me physically. The environment in the institute was dreary, dark and inhospitable. I was thinking that, it's irrational, these children can't harm me, I'm older and stronger than them, but inside I was feeling helpless and terrified like I was going to perish, annihilated. It was like there was nothing to keep me safe from harm. The fear was not realistic at all. They were only children. (Inexp2)

4.1.1.4. Emergence of psychosomatic symptoms

Some participants narrate that they feel physical symptoms accompanying fear. Exp2 states that when a client threatened her physically she experienced these symptoms:

"The client was threatening me, I was trying to stay calm but my blood pressure hit the ceiling and I couldn't move or say a thing. My heart was pounding. I was paralyzed with fear." (exp2)

Exp4 states that when she was working with an abusive patient, she experienced these symptoms:

> "It was a spine-chilling moment. My back suddenly got tightened and I was perspiring a lot. I felt so scared." (exp4)

When Inexp4's client made an offensive comment about her, she experienced these symptoms:

> "There were clouds in my head because of the anxiety that I felt. A state of not being able to think or even see. I was asking questions but I wasn't understanding the answers. My ears were wuthering. I was hearing but couldn't understand anything." (inexp4)

4.1.2. Avoiding revealing feelings

Both experienced and inexperienced psychotherapist participants state that they make an effort to avoid revealing their feelings for several reasons.
Exp1 reportes that when she observed that her client was in a psychotic episode, she tried to hide her feelings because it was the only way she could be helpful in this situation:

> "I was feeling helpless inside, but I was trying to hold on to a protective, compassionate manner. I was in panic, thinking what should we do now?, we need to contact with her/his psychiatrist, family or a friend right now, because the client was not in a state that could be left alone after the session. I was thinking that I shouldn't reveal my feelings. I wasn't calm inside but I should be the one to keep her/him calm. I was trying to keep calm and plan what to do next but inside there was a hurricane, a volcano of feelings that I had a hard time keeping hidden." (exp1)

Exp2 states that when a client threatened her life during the session, she needed to hide her feelings, tried to seem calm and silent not to provoke the client more:

> "Because I know that every word that comes from my mouth at that point will make the situation more dangerous for me. I remember sitting in the room with the client quietly. I felt so helpless and scared. I was trying to seem calm not to provoke the client but my blood pressure hit the ceiling and I couldn't move or say a thing. My heart was pounding. I was paralyzed with fear." (exp2)

Exp4 states that she needed to conceal her feelings when she was working with an abusive client, fearing of being misunderstood and giving the wrong messages,:

> "Sometimes she/he would make a joke, I normally laugh at sessions when a client makes a joke, but in this case I had an urge to hide my feelings, fearing that she/he would misunderstand it and think that I'm flirting with her/him". (exp4)

When Inexp1 couldn't hold herself and cried during a session, she thought that she made a big ethical mistake by revealing her feelings:

> "I mean, crying in a session means revealing my inner world. Revealing myself. It's like a crime for me, it's forbidden, and it deserves a big punishment, like being expelled from the program. A client shouldn't see me, my inner world." (inexp1)

Inexp4 felt the urge to hide her feelings and was scared that her face might be showing her feelings when a client made an offensive comment about her:

> "It was a delicate matter for me. I was very sad and scared that my face might be revealing it. I tried to stay calm and focus on the client, but inside I was feeling anxious and sad." (inexp4)

4.1.3. Sadness

All participants state that they feel sad when working with their clients.
Exp1 narrates that she felt very sad when a client of hers gradually approached a psychotic episode:

> "Seeing a person falling like that… a person I come together in all those sessions, a person I feel related to... Seeing a human being have a psychotic episode, it really came gradually. When I compared the client's state of mind to the previous weeks, I could see that it happened right in front of my eyes and seeing the moment of losing touch with reality, it makes me so sad, both as a therapist and as a person. I remember thinking that not so long ago, my client was making logical inferences, considerations and now my client is making no sense. It's so sad, I remember feeling deeply saddened." (exp1)

When a client got angry with Exp3 and made a complaint about her, she felt very sad because of her client's unfaithfulness:

> "One day, before the session with my client, I got very ill and had to cancel my session. The next week, the client came to me in fury, so angry. After the session I realized that my client made a complaint about me everywhere possible. Fortunately, the institution that my client made the complaint to, decided that there is no need for an investigation and told my client it's a subject that needs to be worked on in the therapeutic process, that there is no ethical violation. I felt very sad. It was a long therapeutic process with this client and we both made great efforts. Seeing my client being ungrateful, unfaithful like that made me feel hurt deep inside." (Exp2)

Exp4 states that she feels so sad when she has to follow the rules of therapeutic frame:

> "When I have to follow the rules of the therapeutic frame with the clients that come to sessions regularly and work well, I feel like a teacher punishing her favorite students, neat and hardworking students. I feel so sad. I feel like somehow I turn into a bad mother…But I always believed that my intentions were not to be a good or bad mother, I want to be a good enough mother, moreover a neutral mother. I ask myself ifI should be more flexible with some rules. Because I believe that we obsess about rules so much as therapists. I remember feeling so strict. Do I obsess about roles so much? Am I becoming so strict? Or is this the exact need of this process?" (exp4)

When Inexp1 was working with a client with a similar background story as hers, she says she felt so sad that she couldn't control herself and cried:

> "In that moment, I felt my client's pain deep inside of me. My pain from my personal life got blended with my client's personal life and I feel so sad and started to cry. Of course I didn't lose myself in tears and cried my eyes out but I cried." (inexp1)

Inexp 4 tells that she felt so sad during a session that she couldn't focus on the client's dynamics anymore:

> "One day my client was so angry with me and said "you don't understand me anyway". At that moment I felt terribly sad and I remember thinking that "it's unfair, if you only knew how our lives and our feelings are unbelievably similar to each other. I felt so sad that I couldn't concentrate on the session anymore that day." (inexp4)

4.2. THEMES SHOWING DIFFERENCES BETWEEN EXPERIENCED AND INEXPERIENCED PSYCHOTHERAPISTS

Below there are main themes that showed differences between experienced and inexperienced psychotherapists when it comes to their experiences of difficult clinical moments. For a theme to be different between the groups of participants, it had to be be narrated by at least two of the four participants in each group.

4.2.1. Feeling Incompetent

While feelings of incompetence was reported by all of the inexperienced psychotherapist participants, experienced psychotherapists that participated in this study stated that they manage to overcome or contain the feelings of incompetence.

4.2.1.1. From first session anxiety to a flexible flow

In the interview Inexp3 narrates her feelings of inadequacy during her first encounter with a client:

> "That was the first time I met with a client like that and in fact I didn't meet many clients in my life. In the first sessions I was like, in a panic, "what should I say now? What should I do now?" I was being convulsed in panic and anxiety and I felt extremely inadequate. I was in agony. My client was staring at me and waiting for a word to come from my mouth. The desperation of not knowing what to say and what to do. Maybe in 10 years I may become a more adequate therapist, I don't know." (inexp3)

Likewise, exp4 tells that she evolved from being obsessed to intake forms to a flexible existence in the room with a curiosity for the client's life:

> "First session anxiety, oh my god I was unable to contain myself. "What will happen now? What should I say now?" I was obsessed with the intake form at that time. Taking notes of every word that came from my client's mouth. Memorizing them. I'm not taking notes anymore in the sessions, because I remember everything. The first session anxiety has now turned into a flexible flow for me. Now when a new client comes, I sincerely am curious about the client's life, I wonder why she/he comes. What's happening in her/his life? I know I'm a mediator, nothing more, I feel so relaxed because of that. I become so flexible, I don't care about the intake form anymore, and my purpose is accompany my client's inner world with a never-ending curiosity."(exp4)

4.2.1.2. From the dreadful drop outs, to accepting the client's capacity of being held

In the interview, Inexp2 says that she experiences the client drop outs as being very unsettling. She narrates her feelings of incompetence:

> "Sometimes I sense that the client is going to drop out. She/he doesn't allow me to relate with her/him, doesn't allow me to get close to her/his safe place and rejects my every attempt of getting closer emphatically. I remember thinking that she/he doesn't love me, like me, I'm annoying her/him. It's very challenging to me. The drop outs are so unsettling and hard for me. I'm still working on this issue, both in my own therapeutic process and in supervisions. I feel my hands are tied. In a therapeutic relationship, I think that the relationship must be strengthened in the first sessions, if that doesn't happen, it's obliged to go to a rupture. Maybe it's unrealistic but I feel like this. I feel so unqualified, unskillful." (inexp2)

Inexp3 states that despite the fact that she doesn't want to work with a client, the client's drop out probability makes her feel inadequate:

> "In fact I don't want to work with this client anymore but if she/he were to say "I don't want to come anymore" I would feel so bad, so inadequate. I would think "in this case she/he doesn't find me helpful, she/he doesn't think I'm a good therapist" (inexp3)

On the other hand, Exp3 states that every client has a capacity of being held:

> "At the beginning of my career my wish to help people was too intense. For this reason I was trying to hold on to every client too much. But today I know that it's wrong. The clients should be held adequately. Neither more nor less. It was one of the areas that I have difficulty in. If I couldn't hold the client, I was blamed myself so much, thinking that the client would have benefitted from the therapy if it wasn't for me, I couldn't hold her/him. I think I overcame this difficulty in the past years. Yes, a mother has a desire to hold her baby in her womb, but babies have a capacity of being held. I shouldn't deny that, but I was trying to. Every baby doesn't get born unfortunately, some of them drop out. Everyone in this profession should accept this fact to be at peace with themselves." (exp3)

4.2.1.3. From being a mother that starves her child to embracing limits

In the light of the interviews, it can be said that satisfying the client has an undeniable importance for the inexperienced psychotherapists. Inexp1 describes her feelings with a malcontent client as being a mother without the ability of breastfeeding:

> "These irredeemable demands of the clients are the end of me. I feel like my hands are tied. I remember thinking that it's a pity that this client came to me and not to a more experienced therapist. I'm unskilled. I feel so inadequate. I feel like a mother with empty breasts, not able to breastfeed her baby. My

client was a hungry baby and I was not able to feed her/him. She/he is so hungry that she/he may bite me, devour me, and annihilate me."(inexp1)

Exp1 says that she faced her limits and accepted the fact that not every client can be satisfied:

"We are human beings. We all have a personal limit. Even if I do the best I can, sometimes it may not be enough. Facing these facts was too hard for me at the beginning of my career. Seeing that I'm unable to cure everyone, meet their demands, and satisfy them…I used to feel so inadequate. The desperation of facing my limits. Now I know and embrace my limits and instead of going hard on myself, I do the best I can and I am at peace with it." (exp1)

Exp2 says that in time she learned to contain and soothe the feelings of incompetence:

"While working with an unsatisfied client, when the client questions my skills, instead of trying to prove her/him that I'm adequate, I'm skilled, I try to understand what she/he feels about my sufficiency. In time I accepted my limits and instead of suffocating in feelings of incompetence, focusing on the client's world always helped me to contain these feelings." (exp2)

4.2.2. Anger management

According to our interviews, inexperienced psychotherapists often feel angry during difficult clinical moments. On the other hand, experienced psychotherapist reported that they can manage and their anger during sessions and knowing that anger is a secondary feeling, focusing what is underneath this anger helps them manage this feeling.

Inexp1 reported feeling so frustrated with an aggressive and unsatisfied client:

> "The clients that have a serious demands from me, that want to feel better instantly, almost expect me to have a magic wand, I'm having difficulties with these kinds of clients. I become agitated and aggressive. I can't stand these kind of sessions. I get frustrated." (inexp1)

Inexp2, reported that she often feel furious about clients that doesn't invest enough to the therapeutic process while she is investing that much:

> "I think that the more the clients open themselves and reveal their inner world, the more helpful the therapists get. When I see a client that is not willing to invest in this process, I get frustrated that instance. I get so angry, because I'm investing to their process too. It's an emotional process for me also, I got into emotional experiences with them. At times like this, I feel like I gave more to this process, I work more, spend my hours, go to supervision, this process occupies a place in my mind and I carry it and when I get angry, it becomes a burden. Then I get angry with myself, because I give too much. I make more effort for their therapeutic process than they do. For example, a client tells me that she/he doesn't want to come to therapy anymore, she/he feels fine, and everything's alright in her/his life. That fine for me but, I need to, we need to make a closure, a termination for this process. When they don't let me, I get angry. If I don't get to make termination sessions with a client, all my efforts go down the drain, the process fails to serve its purpose."(inexp2)

For Inexp3, experiencing the same issues with a client in her private life is infuriating:

> "I'm experiencing similar problems in my life, similar to my client's experiences, when she/he stares at me with an expectation of me solving

her/his problems. I already couldn't find the answers for myself. I get frustrated. I want her/him to try to understand, don't ask me everything like I know all the answers in the world. I get angry right now as I'm telling you these. I get so angry because I'm looking for solutions too, then I tell myself, I shouldn't look for answers either. I can't remain in the state of understanding. My inner world blends with the client's inner world. I'm annoyed by my client, then I say to myself, am I this annoying too?" (inexp3)

Inexp4 experiences so much anger when a client violates the boundaries of the therapeutic process:

"At that point understanding and interpreting their dynamics becomes so hard because I believe that she/he wants to drive me crazy. Thinking about why she/he does it is so hard with this anger in me and I started relating it to my personal life. Started taking it personal. Am I letting people violate my boundaries?"(inexp4)

On the other hand, exp1 claims that she used to feel angry when a client was aggressive towards the therapeutic frame, but she now focuses on trying to understand this need of the client:

"There will always be these kind of clients that are aggressive towards the frame, but now I manage to remain calm. But at the first years of my career, I got angry with this kind of clients so much. I used to wish they would drop out. Then I learned to get out of my inner world and start focusing on the client's inner world and start to see that under the aggressive, tough and spiky barrier of self, there is a fragile, vulnerable inner world, like a little child and the only thing that little fragile child needs is to be understood compassionately. When I discovered it, I stopped getting angry with these kinds of clients. Anger is a secondary, archaic feeling, a therapist should always look to see what's behind it." (exp1)

Exp2 says that she used to be so furious with hardliner clients but now she claims that she focuses on trying to understand what makes that client think that way:

> "I use to get frustrated with extreme hardliner clients that have world-views that are opposite to mine. I used to feel helpless with them, like there are no grounds for us to discuss things on. Then I used to turn to myself and criticize myself, am I intolerant to differences? Am I the hardliner myself? From that point on I decided to focus on my clients with curiosity with the question "what made her/him this hardliner?" my anger got replaced with sadness. I am a human, of course I got angry sometimes, but I don't lose myself in that feeling and focus on the other with curiosity and my anger evolves." (exp2)

Exp4 claims that she used to be very angry with malcontent clients, but now she understands that it's a secondary feeling:

> "I used to feel so angry, so angry, I bursted with anger. Especially with the patients that are unsatisfied with the process, when they expect miracles from me. But now I don't get angry anymore because I know that anger is a secondary feeling, what's underneath is my feeling of incompetence. Once I got over these feelings of inadequacy, I got over anger." (exp4)

4.2.3. Intolerance to uncertainty

According to our interviews, inexperienced psychotherapists often experience the uncertainty related to both difficult clinical moments and the profession itself as unbearable. On the other hand, experienced psychotherapists claim that it gets easier to remain in the uncertainty.

For Inexp4, remaining in the uncertainty and silence is unbearable:

> "A client of mine hardly speaks in the sessions. It's so hard for me because, she/he sometimes doesn't say a single word for me to understand and interpret her/him. This kind of clients that cannot go but cannot stay either drives me crazy. Think that these sessions will go to waste like this. A session in purgatory. I can't stand this uncertainty, it's unbearable. Tolerating silence is so difficult for me. I feel tense, anxious". (inexp4)

Inexp2 claims that being a psychotherapist is a compelling profession because it demands being tolerant to uncertainty:

> "It's a rich but tiring profession. It's ambiguous. One day never resembles another. There are no guarantees to anything. Today I may have 10 clients, tomorrow they could be all gone. Nothing is constant. It's very scary. What will my new client be like? Will she/he be a difficult one? Or a murderer? I can't tolerate uncertainties in my personal life. I'm in fear and anxious. I'm anxious about the future. I invested so much in my career, in my profession, will it pay off? Do I have the patience for it? It's so hard." (inexp2)

For Inexp3, the uncertainty of a first sessions with clients are agonizing:

> "The thing that I experience in first sessions is a complete uncertainty. In the first sessions I'm in agony. What should I say now? What should I do? I panic. How will this process go? Is it going to be a hard client or a good one? Will the client like me as a therapist? Maybe she/he will find me unskillful. I would prefer an experienced therapist, will she/he think like that? Maybe 10 years later I will feel no anxiety in these uncertainties. I will feel comfortable." (inexp3)

In the interview, exp1 narrated that she used to be so anxious about the uncertainties in the sessions, like silence, but now she states that she lets herself go with the flow:

“The difficulties I experience have changed as I grow in this profession. At the beginning of my career, especially in the first sessions, I would get anxious and say to myself what should I do? What should I say? Should I make an interpretation? Is it early or too late? I was completely meticulous. But now every session evolves in a spontaneous way in its natural flow. I know that I don’t have to force it one way or another, the only thing I should do is sit and let it flow. At the beginning, silence was excruciating. When the client was silent, I forced myself to interfere and make her/him tell something. But now…ohhh I’m so comfortable, if she/he wants, she/he can keep quiet all session long. Joking aside, now I know that how important the silence is. To keep track of the client’s history, she/he should be silent sometimes to think, to get deep inside herself/himself. I learned it in time. It feels like learning to dance. At first you try to keep the moves and technique in mind. Memorize the steps, one forward, one backward… but then you star letting yourself go with the rhythm, go with the flow. Dancing the way you want to the rhythm, not counting steps be natural and authentic. Learning that makes this profession enjoyable for me.” (exp1).

5. DISCUSSION

5.1. COMPARISON TO THE PREVIOUS RESEARCH

Although there aren't any existing studies on the comparison of experienced and inexperienced therapists' experiences in difficult clinical moments, some of the themes that have been found as a result of this study are compatible with the prominent research on the therapists' experiences on difficulties in the sessions. These are studies by Davis and colleagues (1987), Schröder and Davis (2004), Orlinsky and Rønnestad (2005) and Smith and colleagues (2007) and Honda (2014). But the following themes in this study, fear of Boundary Violations, Intolerance to uncertainty and Sadness have not been found in any of these previous researches.

Honda's study (2014) is the most congruent one with this study, both by the method of the study and the results. Even though there is a theme of Feeling Fear in Honda's research, it's a more general exploration of feeling fear not mentioning the fear of boundary violations.

In the study of Smith et al. (2007) fear and anxiety have been found as a result, but again the topic of boundary violations was not mentioned. In the other studies, fear or anxiety have not been mentioned. The theme of Avoiding Revealing Feelings in this study is only compatible with Honda's (2014) results. But the theme Sadness and Intolerance to Uncertainty are new findings in this area of research.

The reason that the themes Fear of Boundary Violations, Sadness, Intolerance to Uncertainty and Avoiding Revealing Feelings, are not mentioned in the previous research except for one research might be that the participants of this study do not represent the general population of therapists. But another reason might be that, on the topic of difficulty experiences in the sessions, the focus was mostly on the clients that create difficulty and not the therapists' experiences. Because of that, during interviews that focus on the experience of the therapists, therapists might hesitate to reveal their feelings and avoid disclosing them, which could explain why the theme of Avoiding Revealing Feelings is only found in one study before.

5.2. THE THEMES SHOWING SIMILARITIES BETWEEN EXPERIENCED AND INEXPERIENCED PSYCHOTHERAPISTS

In this section, the themes that show similarities between experienced and inexperienced psychotherapists will be discussed. The theoretical literature related to these themes will be reviewed.

5.2.1. Fear of Boundary Violations

The most dominant theme that emerged from this study is fear of boundary violations. Both experienced and inexperienced therapist often experience feelings of fear. According to this study, fear is mostly experienced by the therapist, in situations involving violations of the therapeutic frame and boundaries. Both experienced and inexperienced therapists state that sometimes they find themselves in clinical moments where they are afraid of violating the boundaries and sometimes they find themselves in clinical moments where they are afraid of their boundaries being violated.

In this study, both experienced and inexperienced participants find themselves in a place where they both desire and fear boundary violations. They report feeling both a desire and a fear of merging with the client. They fear that if they experience this merger, they will be engulfed by the client or because of their own fear of abandonment, they will engulf the client themselves.

These fears and desires seem like a reenactment of a mother and child relationship in the early years of life, especially the separation-individuation process. Clients with borderline personality organization level, on the one hand, feel the terror of engulfment and being controlled and they have fears of annihilation in close relationships, on the other hand, when they experience separation, they feel like they are being abandoned. They get no relief in a relationship, because neither being close nor being separated is comfortable for them. They remain in a constant state of anxiety and fear in relationships. According to Masterson (1976), clients with

borderline organizational level are stuck on the reapproachment phase of the separation individuation process. In her article "On the First Three Sub-phases of the Separation-Individuation Process", Mahler (1972) states that a child in the reapproachment phase has earned a specific autonomy, but needs to feel that her/his mother is around, available and able to look after her/ him. This phase is observed at the age of two. The child rejects the help of her/his mother and insist on doing things on her/his own and then regresses and runs back to her/his mother. This is a natural developmental behavior of the separation-individuation process. In this situation, the mother has to be available and trustworthy. Masterson (1978) states that a borderline level client's mother is unwilling to separate at the separation individuation process of the child. They try to prevent the child's attempts of individuation by merging with the child and this merging evokes fears of engulfment and annihilation. When the child needs his mother at the reapproachment phase, the mother is not available, the mother punishes and abandons the child for his attempts of individuation and the child develops fears of abandonment. These problems cause a developmental arrest in this process, so the child gets stuck on this phase. Just like in every relationship in their life, borderline level clients feel vulnerable in the therapeutic relationship.. Relationships are terrifying for them. They shuttle between a state of merger where they experience fear of engulfment and a hostile separation where they feel abandoned (McWilliams, 1994). Because of these inconsistencies in their ego state, working with clients with borderline level of organization requires consistent conditions. These consistent conditions are called the therapeutic frame. The matter to be paid attention to here is to maintain consistency and the continuousness of the determined therapeutic frame rules, which can be interchangeable from client to client. What these rules are, is not the important matter in this situation (Geist, 2009).

In accordance with the existential perspective, Laing (1969), states that the fear of engulfment is a result of the individual's ontological insecurities. The development of a baby's being-for-itself is dependent on the loving and caring relationship between the mother and the baby. The mother lets her baby experience the world

like a mediator. If the world that is presented to the baby is manageable, it provides ontological security; if not, the baby becomes ontologically insecure. Ontologically insecure individuals constantly feel fears of engulfment in their relationships.
According to Laing's own words in his work "The Divided Self":

> *"Engulfment is felt as a risk in being understood (thus grasped, comprehended), in being loved, or even simply in being seen. To be hated may be feared for other reasons, but to be hated as such is often less disturbing than to be destroyed, as it is felt, through being engulfed by love. The main maneuver used to preserve identity under pressure from the dread of engulfment is isolation" (Laing, 1969, pg. 42).*

While working with a client with separation individuation issues or ontological insecurities, at the core of the therapeutic relationship lies the matter of boundaries. But sometimes the therapist sets harsh and externally imposed rules and boundaries to the relationship because the therapist may feel overwhelmed the countertransferencial feelings of fear. But these harsh rules and withdrawal may harm the connectedness in the dyad (Geist, 2009).
Every therapeutic dyad requires a state of connectedness. According to Kohut, connectedness is crucial in both developmental stages of life and in therapeutic situations. Kohut states that the development of self cannot be possible without an experience of a self-object and connectedness is a necessity for this. For the development of a healthy sense of self, mirroring, idealizing and twinship is needed from the self-object. Likewise, in the therapeutic dyad, connectedness between the therapist and the client is what makes the "healing" possible. (Kohut, 1971, 1977, 1984). In the safety of connectedness, the organization of a healthy sense of self can evolve. A therapeutic relationship with a sense of connectedness between the therapist and the client helps the healing of the client's early self-object deficits by reenacting the developmental stages of life and it lets the client maintain a healthy sense of self (A. Ornstein, 2006).

Connectedness is a situation where two people feel, share, experience and respond to each other's inner worlds. In other words, through connectedness, the therapist, feels the presence of the feelings and experiences of their client's subjective world inside their own subjective world. Therefore, the boundaries between two people cannot be rigid. In order to maintain connectedness between the therapist and the client, the boundaries should be permeable (Geist, 2008). According to Kohut, the self is not confined by physical boundaries. Even if we assume that there is an asymmetrical relationship in therapeutic dyad, in the connectedness between the therapist and the client, experiential feelings are shared fluidly through the permeable boundaries of their selves. (P. Ornstein & A. Ornstein, 1994). According to Geist (2008), if a therapist pursues to heal her/his clients, connectedness is a necessity. As the therapist and the client become a part of each other's experiential worlds, the therapist can deeply understand the client's feelings, not from her/his own external point of view, but from right inside the client's experiences. As the therapist becomes a part of the client's experiential world, the client develops a self-object transference and becomes more able to understand what happens inside her/his experiential world from the therapist's responses to these shared feelings. This experience helps the client to restructure herself/himself.

However, there is an aspect of the connectedness in the therapeutic relationship that lets the therapist experience fear and retreat, because in the connectedness, the boundaries can't be predefined. The boundaries may change and evolve in the consequences of the connectedness of the therapeutic relationship. As the clients see their therapists as a part of themselves, they conclude that their therapists' self-boundaries are the same with their self-boundaries (Geist, 2009). According to Kohut (1977), there is a similarity between a person's understanding of boundaries of herself/himself and those of her/his self-object. So, when a client expresses her/his wishes to explore these boundaries, it's sometimes perceived by the therapist as attempts of boundary crossings. Most of the attempts which seem to be boundary violations are in fact the client's wish to see that the connectedness between them is real. The client wishes to see that if the therapist is experiencing the client's presence in her/his experiential world. Also, the client tries to recreate

her/his own boundaries by getting in touch with their therapist's boundaries while experiencing the therapist's presence in her/his experiential world,. So, what seems to be a boundary violation is sometimes a way of healing (Geist, 2009).

Clients, with a purpose of healing, experience a "continuation of an early reality" in the therapeutic dyad (Kohut, 1971). Especially clients with the borderline level of organization, because of their early experiences of neglect and failure of self-object relationships, tend to look for a new and stable self-object in the connectedness of the therapeutic relationship, wish to be recognized and accepted with some acts, but this pursuit is often perceived as boundary violating behavior. When therapists are in a connectedness with their clients, sometimes they feel threatened, because of the permeable boundaries, they feel their clients' presence inside and likewise the clients experience the therapists' presence and this creates a feeling of vulnerability. The therapist may feel a fear of disintegration of their self, but externally imposing rigid boundaries in order to overcome these fears towards the clients' acts restrains the healing process and disrupts the connectedness (Orange, Atwood, & Stolorow, 1997; Geist, 2009).

To sum up, as it can be seen in the results of this study, in the connectedness of the therapeutic dyad, especially with clients who have separation-individuation issues, the therapist may feel countertransferencial feelings of terror of engulfment from the attempts of merger by the client, likewise in the situations of withdrawal of the client, they may feel a desire to merge and a fear of engulfing the client.

5.2.2. Avoiding revealing feelings

Avoiding revealing feelings, in other words, avoiding self-disclosure of feelings is a common theme between the inexperienced and the experienced therapist when it comes to the difficult clinical moments. It can be observed in the results of this study that therapists avoid revealing their feelings for several reasons. One of them is to maintain the stable and protective therapeutic environment and to keep the client calm. Another reason for the therapists to try to hide their feelings is the fear of being misunderstood, so by hiding their feelings, they try to avoid giving the

wrong messages to clients that might lead to a boundary violation. Lastly, as a result of this study, it has been found that therapists hide their feelings, because they believe it's forbidden in the therapeutic process and harmful for the client and it might lead to an ethical violation.

So, according to the results of this study, it can be concluded that the main concern of the therapists on the avoidance of self-disclosure is about maintaining the therapeutic frame, moreover, they avoid revealing feelings in fear of making a boundary violation themselves or letting the client make a boundary violation. I discussed these concerns above in the section "Fear of boundary violations".

There is an aspect of the therapist's self-disclosure that is argued to be harmful for the therapeutic process, suggesting that it risks the boundaries of the therapy and leads to unethical practice (Goldstein, 1994). It is argued that it may lead to the disruption of the focus on the client and may draw the attention to the therapist's own self (Wachtel, 1993). According to other ethicists, the therapist's self-disclosure always leads to the crossing of boundaries (Gutheil & Gobbard, 1999).

As mentioned before in Chapter 2 Results, Martha Stark (2000) divided psychoanalytic approach into three models in her book "*Modes of Therapeutic Action"*:

- Model 1; the drive-conflict model represents the classical psychoanalytic theory that consists of Freud's drive theory and ego psychology. One person psychology.
- Model 2; the developmental arrest model represents the objects relations and self-psychology theories. One and a half person psychology.
- Model 3; the relational conflict model represents relational and intersubjective psychoanalysis theories. Two person psychology.

According to Stark (2000) each model's approach to self-disclosure is different.

In the traditional psychoanalytic point of view, the drive-conflict model, self-disclosure is unacceptable. Freud states that therapists shouldn't reveal anything that represents their personality. Like a "blank slate", therapists should act as a mirror that reflects only what the client brings to the room (Freud, 1912). But this point of view might be unhealthy for the therapeutic process. Because if therapists

stay in a detached and cold presence in the room in order to prevent self-disclosure, clients might feel uncomfortable, distressed and this might prevent them to open up and safely bring their feelings to the therapy room.

In the developmental-arrest model, which is considered as one and a half person psychology, as mentioned in Chapter 2, empathic attunement is a very important tool to help clients heal the wounds of their past and develop a new healthy self (Stolorow et al., 1987). From this point of view, the therapist's countertransferencial feelings are regarded as a crucial source to understanding the client's material, but disclosing these countertransferencial feelings is seen as a restriction to the client's self-development. Nevertheless, according to Ferenczi (1932), the effort to remain undisclosed as a psychotherapist is both impossible and vain, because no matter how much we try to disguise ourselves, the clients sense our presence more than we predicted they would (as cited in Ehnerberg, 1995; Renik, 1999). Moreover, self-disclosure gives both the client and the therapist an opportunity of an authentic expedition and gaining an understanding of their selves (Greenberg, 1995; Ehrenberg, 1995).

According to Stark (2000), in the relational-conflict model, the Model 3, the relationship between the therapist and the client is an authentic and real relationship. In this real relationship, clients have an opportunity to understand their relational dynamics as they engage more deeply. In this real relationship, the countertransferencial feelings of the therapist are regarded as a crucial source of understanding the client's material, just like in Model 2, however in Model 3, when used responsibly, the disclosure of the countertransferencial feelings are considered to be extremely important as a therapeutic resource. According to the several studies on this topic, self-disclosure in the therapeutic process serves as a "humanness" agent and maintains a ground for the clients to relate to these authentic therapists (Farber, 2003; Fisher, 2004; Hill et. al, 1988; Rachmann, 1998). So, according to contemporary views about the therapeutic process, self-disclosure of the therapists is not harmful, on the contrary, it is considered to be a beneficial incident for the sake of the therapeutic process and it provides for the therapeutic dyad (Al-Darmaki & Kivlighan, 1993; Barrett & Berman, 2001; Safran & Muran, 2000). In the

therapeutic dyad, self-disclosure creates an open and affectionate environment and the openness of the therapists helps the clients open themselves up more easily (Jourad, 1971). Weiner associates self-disclosure in the therapeutic dyad with a real relationship and defines it as "being oneself". Therapy is referred as a genuine relationship of two people coming together in the existential view, so the self-disclosure of the therapist is favored (Weiner, 1978). Self-disclosure of the therapist reminds the clients that they are not alone in the suffering that they are in (Yalom, 1975).

As mentioned above in a therapeutic relationship, self-disclosure is inevitable and useful, but the timing of it is an important issue. According to Nancy McWilliams (1994), it's considered more useful for specific clients. McWilliams (1994) states that while with healthier, "neurotic-level" clients, the therapists should be less revealing in order to leave space for the client's exploration, whereas with the more disturbed clients, the disclosure of the therapist's feelings and experiences is an important tool to help increase the client's perception of reality and validation of their emotions and experiences.

In a study by Wagner and colleagues (1997), a doctor states that she hides her tears from her patient. She avoids revealing her feelings, avoids self-disclosure. Maybe showing the tears, showing the feelings makes the situation too personal and makes the relationship too real. In this study, participants also avoid showing their feelings and tears this due to fears of boundary violation. In the light of the existing literature, being open and disclosing, "being oneself" in the room, being in the connectedness of the therapeutic dyad makes the relationship feel too real and therapists feel vulnerable in this realness. According to Susie Orbach (2014), it is the only way to be in a relationship. Because if one component of a relationship is unaffected, it cannot be considered as a relationship. Orbach (2014), criticizes the idealized neutrality in the therapy and considers it as a tool of taking distance from the clients. Being in a real relationship with a client in which the therapist feels affected does not mean that the therapist loses her/his therapeutic functions and her/his own agency. In the therapeutic relationship, therapists are co-participants and being in a real relationship is disclosing without the need to conceal their

feelings. The way the therapist is an authentic being in the relationship itself is a disclosure.

5.2.3. Sadness

Another common theme that both inexperienced and experienced therapists reported is feelings of sadness during difficult clinical moments. In the therapeutic process, the client and the therapist are in an intimate relationship. The therapeutic process requires a connectedness as mentioned in the discussion of the common theme one. In therapy, therapists accompany clients, while their most traumatic experiences come flooding back and the client's pain is saddening all by itself.

In this study, participant's state that seeing a client's state deteriorate, like an approaching psychotic episode, is depressing. A client's behavior which is destructive for the therapeutic process is also reported as a saddening situation. According to the results of this study, following the rules of the therapeutic frame can make a therapist feel punitive like a bad mother and sharing similar background stories with a client can make a therapist overly identify with the client and share their sadness deeply.

As mentioned in Chapter 2, according to Stark (2000), in the Model 2 therapeutic dyad, when the therapists engage with clients, therapists decenter from their inner world experiences and start experiencing the client's inner world as their own inner world. This approach is called empathic attunement. According to Heinz Kohut (1971), empathy consists of therapists decentering from their inner world experiences and immersing themselves in the clients' inner world experiences. However, in the Model 3 therapeutic dyad, when therapists engage with clients, therapists don't decenter from their inner world experiences; they continue experiencing their inner world, while letting the clients' inner world enter their inner world and they experience their inner world as their own inner world. This approach is called authentic engagement.

For example, when a client is sad, the Model 2 therapist, decenters from her/his emotions and gets immersed in that sadness. The therapist feels sad but it is not

her/his own sadness, it is the client's sadness The therapist understands what it is like being so sad and this way, the client feels understood deeply. In the same situation, the Model 3 therapist does not decenter from her/his emotions, the sadness that she/he feels is her/his own sadness that emerges in relation with her/his client. In this case, the sadness is not just the client's sadness anymore, it is both the client's and the therapist's sadness. The therapist genuinely feels sad. This helps the client be in touch with her/his overwhelming feelings. The client feels that she/he is not alone in this suffering and this way the client becomes able to get more in touch with her/his feelings, instead of trying to avoid them. The Model 2 therapist and Model 3 therapist act differently with the feelings of sadness. While Model 2 therapist remains in an understanding and validating stance and does not bring her/his countertransferencial feelings into the room, the Model 3 therapist brings her/his feelings, vulnerabilities and tears of sadness into the room. Sometimes the feelings become so overwhelming that the client avoids, suppresses or denies them. When a client becomes detached from her/his feelings, unable to feel sadness, the therapist may still feel very sad. The client makes her/his therapist experience the feelings that she/he cannot tolerate to experience. It becomes a co-created sadness that the therapist feels. The therapist's toleration and processing of these feelings helps the client get in touch with her/his feelings and tolerate them more easily.

5.3. THE THEMES SHOWING DIFFERENCES BETWEEN EXPERIENCED AND INEXPERIENCED PSYCHOTHERAPISTS

In this section, the themes that show differences between experienced and inexperienced psychotherapists will be discussed. The theoretical literature related to these themes will be reviewed.

5.3.1. Feeling Incompetent

The most dominant theme that resembles a difference between experienced and inexperienced therapists is the feeling of incompetence in the difficult clinical

moments. In this study, while inexperienced therapists indicated that they experience incompetence intensely during the therapeutic process, experienced therapists stated that they managed to overcome the feelings of incompetence as they gained experience in the profession. Inexperienced therapists reported feeling incompetent in several difficult situations in therapy.

For instance, while an inexperienced therapist narrated that she felt convulsed with panic and anxiety and felt extremely incompetent, an experienced therapist stated that she evolved from being obsessed with intake forms to a flexible existence in the room with a curiosity for the client's life. Another example is the reactions to drop outs. While an inexperienced therapist stated that she experiences the client drop outs as very unsettling, fearing that the client doesn't love her and feeling annoyed by her. One of the experienced therapists reported that she evolved from trying to hold on to every client too much, to having an understanding that every client has a capacity of being held. She stated that, a mother desires to hold her baby in her womb but babies have a capacity of being held. Lastly, in the difficult moments with unsatisfied clients, one of the inexperienced therapists narrated feeling like a mother who is unable to breastfeed her baby. On the contrary,one of the experienced therapists reported that she faced her limits and accepted the fact that not every client can be satisfied.

These findings resemble the difference between self-knowledge and self-awareness. While self-knowledge can be described as a retroactive perception of the inner dynamics of one's self, self-awareness can be described as a current perception on the inner dynamics of one's self. Even if they sound similar to each other, self-knowledge of the therapist is evaluated as helpful for the therapeutic process, whereas self-awareness may cause disturbance for the therapist, because it causes therapists to question their own adequacy, reveals feelings of incompetence and affects their performance in therapy negatively (Safran & Muran, 2000). The feelings of incompetence that therapists experience may cause low self-respect (Thériault & Gazzola, 2005), depressive mood (Mahoney, 1991), stress (Farber & Heifetz, 1982) and physical or mental collapse caused by this stress (Deutsch, 1984). They may experience alienation from being a therapist (Tériault & Gazzola,

2005). In other words, feeling incompetent is considered to be harmful for therapists both personally and professionally. Every therapist may feel incompetent during their career, but these feelings are mostly experienced when the therapist is inexperienced.

As a result of this study, it has been found that inexperienced therapists struggle with feelings of incompetence, because they constantly keep their focus on their inner psychological state, their self-dynamics and how they might be seen from the perspective of the client. This state of over introspection and self-awareness has been found harmful for both the therapist and the therapeutic process, compatible with the findings of previous researches (Williams, Hayes, & Fauth, 2008; Williams et al., 2003; Thériault et al., 2009)

On the other hand, experienced therapists that once had these feelings of incompetence found ways to overcome and cope with these feelings. Firstly by accepting and embracing their own limits as a person and a therapist, secondly by accepting the client's limits and accepting the fact that not every client can be healed, that every client has a capacity to be held and lastly by keeping the curiosity for the client's inner world alive and focusing on it, instead of focusing on their own ongoing internal state of feelings.

5.3.2. Anger management

Another theme that differentiates between inexperienced and experienced psychotherapists is anger management. In the interviews, inexperienced therapists often report that they feel angry during difficult clinical moments, whereas experienced therapists are more able to manage their feelings of anger and hate according to the results of the study. Inexperienced therapists reported that they feel angry while working with demanding and unsatisfied clients, with clients that do not invest to the therapeutic process, with clients that experience difficulties that the therapist experiences in her personal life and with clients that violate the boundaries.

However, experienced therapists reported that they can manage their anger in several ways. Focusing on trying to understand the client's inner world, the client's needs of acting outs, instead of focusing on the therapist's own feelings is one of them. Another way experienced therapists use to manage their anger is trying to understand what lies beneath this anger.

In the literature, therapists' feelings of anger is mostly a neglected topic, but there are some studies on this, which suggest that the emergence of anger might be seen as favorable to the therapeutic process, because the situations that make the therapist angry can only emerge if the client trusts the therapist (Cahill, 1981). Anger is seen as an ego defense against the anxiety that the feelings of vulnerability creates (Rothenberg, 1971). Therapists' anger can also be seen as a countertransferencial response. According to Singer (1969), understanding whether this feeling emerges from realistic reasons, like negative experiences with the clients or the therapist's own countertransferencial reactions, is very important. Winnicott (1949) in his article *Hate in Counter-transference,* states that feelings like anger and hate are inevitable while working with difficult clients. Winnicott names this reaction *Objective Countertransference*. While working with difficult clients, therapists experience stress and anger, which emerge from the client's unsatisfiable demands and needs. In these situations, although it's very difficult, the therapist must keep her/his hate and anger latent. In the mother-child relationship, a good enough mother keeps her anger, which emerges from the child's extreme needs latent, until the child develops an ego capacity to relate with and understand this anger. In the therapeutic relationship, the role of the therapist is to be a good enough mother for the client. In this process, the client regresses and a reenactment of the early relationship occurs. The therapist must keep her/his anger latent like a good enough mother until the client develop a healthy ego capacity (Winnicott, 1949). Fremont and Anderson's study (1988) investigated the factors that makes therapists feel angry in the therapeutic process and found that the anger response of the therapist mostly emerges from the client's boundary challenging and over demanding behaviors. Not knowing if this feeling that they experience is appropriate, not understanding why they are feeling it, if it is ethical to feel it and

what should be done about it, makes anger a challenging feeling for therapists and thoughts create an uncertainty. While therapists with more experience can tolerate this uncertainty, less experienced therapists might have less control over this anger and it might become disruptive for the therapeutic process (Fremont and Anderson, 1988).

5.3.3. Intolerance to uncertainty

As life itself brings us uncertainty in many aspects and it sometimes becomes unbearable for people, the psychotherapy profession, being a therapist and being a part of a therapeutic process comes with a feeling of uncertainty and tolerating the uncertainty can be hard for the therapist both as a person and as a professional. In this study, inexperienced therapists reported that they are intolerant of the uncertainties of both the difficult clinical moments and profession itself. On the other hand, experienced therapist that participated in this study, stated that it became easier in time as they gained experience to tolerate uncertainty. Especially tolerating the silence in therapy, even if it is an important aspect of the therapeutic process, is hard for inexperienced therapists. Experienced therapists reported no discomfort about the uncertainties of the therapeutic process. In the interview, one of the experienced therapists narrated that she used to be so anxious about the uncertainties in the sessions, like silence, but now she states that she lets herself go with the flow.

In my opinion, these statements explain the reason for the anxiety towards uncertainty in both therapeutic process and life itself. Trying to control the uncertainties that life brings and uncertainties in sessions is impossible, as Exp1 says it is like trying to memorize the steps and keeping the technique in mind while dancing. Counting the steps disrupts the authenticity and nature of the dance. Dancing requires letting go with the flow, just like in life and it is essential for the therapeutic process as it is a reenactment of life.

According to Keenberg's study (2015) on clinical psychologists' lived experiences of uncertainty, therapists feel anxious and threatened in the presence of uncertainty

and this might lead them to actions to decrease this uncertainty, have control over it or totally deny it. These attempts might lead to rigidity in treatment that might not be in the best interest of the therapeutic process.

Uncertainty in psychotherapy is an issue that is explored in existential psychology mostly. Existential philosopher Martin Heidegger conceptualizes human's *dasein* (being-in-the-world) as naturally uncertain because of its ever-changing nature. According to Heidegger, there are ontological givens of human beings that are natural givens of human existence. One of them is called *Unheimlichkeit,* which means not being at home, not belonging. Because human beings are temporary in this world and this creates an unease that cannot be overcome. So, being human brings uncertainty. It's a fundamental part of the human existence. Working with the *dasein* of the client is the purpose of the existential psychotherapy. Settling and working with what comes to the therapy room is the key to understanding the clients state of being-in-the-world. (Van Deurzen, 2010). Working with the *dasein,* brings uncertainty. Accepting this uncertainty, not trying to reduce it by trying to find meanings in what lies beneath the content that comes to the therapy room and accepting the client's presence in the room as it is the principle of existential therapy. According to Cohn, trying to maintain a certainty about the therapeutic process is impossible and unnecessary for the healing of the client. With the effort of the therapists, being with client and devoting themselves to the client without an act to reduce uncertainty, therapists can come together with their clients and relate to their state of being-in-the-world authentically. Healing only becomes possible with this authentic meeting (Cohn, 2002). According to Yalom (1980), in order to get control over the things that are uncertain, people tend to rely on explanations and likewise therapists may hold on to the causes and diagnosis of symptoms of their clients. This is an effort to control the uncertainty in the therapeutic process. But in fact any act in psychotherapy is valuable when it is done in the best interest of the client and not to ease the anxiety of the psychotherapist. Having a diagnosis is not helpful for many clients and in many cases a diagnosis is used for reducing the uncertainty. Yalom stated that learning to tolerate uncertainty is an important

stage in the maturation journey of the therapists. Therapists should learn to embrace and be flexible in the face of uncertainty (Yalom, 1980).

6. IMPLICATIONS OF THIS STUDY

In this chapter, the implications for psychotherapists, trainers and supervisors that emerge from the results of this study and the discussions of these results of this study will be elaborated. However, it should be noted that these implications are largely influenced by my subjective understanding of the results of this study, and my subjective experience as a psychotherapist.

6.1. IMPLICATIONS FOR PSYCHOTHERAPISTS

This study's purpose was to gain insight on how a psychotherapist makes sense of, gives meaning to their subjective experiences of what they define as a difficult clinical moment and to explore how these moments affect their private and professional life. According to the results of this study, the following implications for the psychotherapists have been emerged. These implications are believed to help psychotherapists, especially inexperienced psychotherapists understand the meaning of their experiences, encourage them to seek help and guidance when they need, help improve their clinical practice and their motivation about being a psychotherapist.

6.1.1. Accepting that the therapeutic relationship is a real relationship

The therapist-client relationship is the main issue of this study. All of the difficulty experiences that have been narrated in this study are about the therapists-client relationship. So it is important to remark on the importance of this relationship. It should not be forgotten that, even though it is different than our daily relationships, therapist-client relationship is a real relationship. A special kind of relationship, but a real one.

6.1.2. Accepting that it's normal to be affected in the connectedness of the therapeutic relationship

It should always be kept in mind that like in every relationships, each person in the therapist-client relationship can be affected by each other. So it is normal to have feelings and experiences in the therapist-client relationship. Moreover, as mentioned before, therapeutic relationship needs a state of connectedness and according to Kohut, connectedness is what makes the healing possible. In the state of connectedness, the boundaries become permeable and the transference of the emotions through these permeable boundaries is what makes the participants fear mostly in the therapeutic relationship. So it is important to accept that it is the nature of the therapeutic relationship.

6.1.3. Resisting the idealized image of being a flawless and invulnerable psychotherapist

As a result of this study, especially inexperienced therapists tend to see their experiences in difficult clinical moments as problematical and even pathological. This understanding leads to personal emotional problems, feelings of incompetence, feeling ashamed of these experiences, having difficulties in disclosing these experiences to supervisors and losing motivation about being a therapist. It should always be kept in mind that, as therapists, we are not immune to difficulties. On the contrary, we are in a vulnerable position in the therapeutic relationship. So, we need to resist the idealized image of being invulnerable, flawless therapists. We are wounded healers, we are in this profession because of our wounds and we become rewounded again and again in the therapeutic relationship.

6.1.4. Disclosure in supervisions is beneficial

Therapist's self-disclosure helps clients in many aspects. It normalizes and validates client's feelings and emotions, contributes to the real relationship between the therapist and the client, closes the distance between them, helps the client feel safe, understood and that she/he is not struggling alone and helps clients share their feelings more openly without any judgment (Hill & Knox, 2002). Since the therapist-client relationship is a real relationship, it can be assumed that the disclosure of feelings is beneficial for all relationships, including trainer-trainee and supervisor-supervisee relationships in the profession of psychotherapy. As a result of this study, some inexperienced therapists reported that although they want to share everything with their supervisors, they feel that their supervisors get judgmental and accuse them for their mistakes, because they do not want them to make mistakes and hurt clients. They reported feeling like supervision is not a place for their subjective difficulties that they experience in the sessions and they feel ashamed of talking about them. They reported that they need to feel that it is normal to experience these feelings, they need their supervisors to be more empathetic, understanding and validating. So, according to the narratives of the participants, disclosing difficulties to supervisors is a major issue. In their study, Orlinsky and Ronnerstad (2005) have found that, when they ask therapists to give a rating from 0 to 5 for their tendency of asking for help after difficulty experiences, an average of 2.79 emerged as a result. In another study, it has been found that therapists fear losing reputation and avoid disclosure of the difficulties that they experience (Thériault & Gazzola, 2005). In another study, it has been found that, 91% of trainee therapists sometimes do not share their difficulties with their supervisors (Yourman & Farber, 1996). Lastly, according to another study, 97% of trainee therapists admit that they sometimes avoid disclosing important materials to their supervisors (Ladany and colleagues, 1996). According to Farber (2006), both inexperienced and experienced therapists tend to have difficulties in disclosing information to their supervisors. Farber states that, the reason for this avoidance of disclosure could be the shame culture in the psychotherapy profession. Trainee therapists got

used to not disclosing their difficulties, because they are ashamed of being judged and this becomes a habit and they continue the non-disclosing to keep their reputation. (Farber, 2006). In the book called "*What Therapists Don't Talk About and Why"*, it is stated that there is a culture in the psychotherapy profession which suggests that a good therapists should not be vulnerable to difficulties in the therapeutic process. This became a tradition in this profession, which was transmitted between generations, from supervisors to supervisees (Pope et al., 2006). Summing up, as it's normal to not being able to get along with everyone in relationships, it's normal to have problems in supervisee-supervisor relationships. But it doesn't change the fact that a psychotherapist can always find a supervisor more suitable for his/her needs. So, especially inexperienced therapists shouldn't give up on supervision, should look for a compatible supervisor that is more open minded, understanding and validating.

6.1.5. Embracing the uncertainty of therapeutic relationship

As every relationship, therapeutic relationship is full of uncertainty. As mentioned in the Discussions chapter, embracing this uncertainty, not trying to reduce it by trying to find meanings in what lies beneath the content that comes to the therapy room and accepting the client's presence in the room is essential for being in a connectedness with clients and relating with their state of being-in-the-world authentically. This authentic meeting is what makes the healing possible (Cohn, 2002).

6.1.6. Self-care is crucial

Being a psychotherapist is very difficult. Being compassionate and empathic for those people who suffers, sharing their sufferings, carrying their intolerable feelings, trying to heal their wounds in the risk of being wounded ourselves... So it's normal that sometimes it feels too much. At this point self-care becomes crucial. There are sorts of self-care activities, such as: relaxing activities like meditation,

yoga and being in the nature. Taking social support of friends, family and colleagues is also important for sharing the burden that we naturally carry as therapists. Attending to hobbies and enjoyable activities is also important. But maybe the most important one is taking professional support. Being in our own psychotherapy process and taking supervision from a supportive supervisor. So self-care is essential for being a competent therapists because therapist's own self is the most valuable tool of therapy and we must take good care of it.

6.2. IMPLICATIONS FOR EXPERIENCED PSYCHOTHERAPISTS, INSTRUCTORS AND SUPERVISORS

6.2.1. A change in the authoritarianism of the psychoanalytic education

Otto Kernberg (2000; 2016) expressed his thoughts about the psychoanalytic based education and the position of the education institutes on this matter in several articles. He criticized the rigidity and the authoritarianism of the psychoanalytic educational system. He manifested that the psychoanalytic based education institutes tend to *"infantilize"* the students, tend to isolate themselves from the modern perspectives of psychotherapy, don't care about the total educational experience of the students, maintain an authoritarian attitude, rigidly impose outdated psychotherapy techniques and idealize a certain way of practicing psychotherapy or psychoanalysis.

In this study, the theoretical orientation of the psychotherapists that volunteered to participate was psychodynamic psychotherapy and they were all from a similar educational background. According to the results of the study, while inexperienced psychotherapists that participated in the study, tend to have a perspective of practicing psychotherapy more rigid, traditional and one person psychology oriented, experienced psychotherapists tend to embrace a perspective of practicing psychotherapy more flexible, contemporary and two person psychology oriented. The difficulties of the inexperienced therapists that participated in the study tend to be more about rules, ethics, prohibitions and uncontrollable aspects of the

psychotherapy. The reason of this difference between two groups might be the fact that the inexperienced therapists in this study are still a student of a psychoanalytic oriented master's program or graduated recently. So the rigidity of their perspective about psychotherapy or their expectation of being an idealized, error-free, invulnerable, flawless therapist might be the product of the traditional, authoritarian education system. Incorporating contemporary educational perspectives, adopting a flexible attitude and being open to diversities might be a way for instructors, supervisors and education institutes on helping students and inexperienced psychotherapists with the difficulties of the profession and the psychotherapy practice.

6.2.2. Self disclosing as a supervisor

According to Honda's study (2014), as a solution to the widespread problem of non-disclosing difficulties, it has been found that the difficulty disclosures made by experienced therapists and supervisors, normalize the difficulty experiences and help trainees and inexperienced therapists overcome the shame that emerges from the difficult clinical experiences, which helps them share these experiences more easily. Like the positive outcomes of therapists self-disclosure to the clients as mentioned above, inexperienced therapists benefit from disclosures that experienced therapists make. These disclosures make them feel like they are not alone, the feelings that they experience are normal and there is nothing wrong about being vulnerable. In the book *What Therapists Don't Talk About and Why,* it is stated that exploring difficulties is only possible in a safe environment. This safe environment can be created by supervisors and trainers by their own openness about their vulnerabilities, which then motivates the supervisees to also be open and honest about the difficulties that they have in the therapeutic process (Pope et al., 2006). In a research, it has been found that supervisees tend to share their difficulties more easily with supervisors who disclose and normalize their difficulties. According to this, supervisors disclosing difficulties helps supervisees be motivated about the profession, improve their relationships with their clients,

decrease their anxiety, decrease their expectation of being an error-free, invulnerable, flawless therapist and this helps them with their feelings of incompetency (Ladany et al., 2001).

7. LIMITATIONS OF THE STUDY AND RECOMMENDATIONS FOR FUTURE RESEARCH

7.1. LIMITATIONS OF THE STUDY

7.1.1. Researchers experience

One of the important limitations of this study was the researcher's inexperience in IPA research. This was the first time the researcher conducted an IPA research and this area of research needs years of experience, but still the researcher dedicated herself to this study and conducted the study meticulously.

7.1.2. Sample size

Another limitation is the sample size in this study. Because of the fact that a qualitative research design was used, the sample size was small, so the results might not be an accurate representation of the general psychotherapist population. But the purpose in this study was not to make a statement about the general psychotherapist population; its purpose was to make a phenomenological analysis of the meaning of the difficulty experiences. In a study where a phenomenological is conducted, the sample size is usually small because of the time consuming data (Mason, 2010).

7.1.3. Gender of the sample

Because of the fact that no male psychotherapists volunteered to take part, this study only included female therapist. The difficulties experienced in therapeutic process may or may not change with the gender characteristics. Nevertheless, the fact that no male psychotherapists volunteered to take part in a study that includes disclosure of the difficulties evokes curiosity and can be a subject of further research.

7.1.4. Personal backgrounds, personality dynamics and past traumas of the sample

The personal backgrounds, personality dynamics and past traumas affect our way of experiencing incidents. These factors might affect the way psychotherapists experience the difficult clinical moments. But in this study, no data about the personal backgrounds, personality dynamics and past traumas of the participants have been collected. The results of the study have been discussed with the data collected in the interviews.

7.2. RECOMMENDATIONS FOR FUTURE RESEARCH

7.2.1. More studies on this area

Psychotherapists' self-care and motivation about being a psychotherapist is very important for the wellbeing of this profession. Difficulties of being a psychotherapist and the difficult clinical moments create a risk especially for inexperienced therapists. So, in order to maintain the wellbeing of this profession, qualitative and quantitative studies should keep their focus on this area.

7.2.2. Studies on each specific themes

In addition to that, each of the experiences that have been found as a result of this study could be examined specifically.

7.2.3. Personal dynamics relation with difficulties

A comparison between the therapists' personal dynamics and the difficulty experiences could also be an area for further research.

7.2.4. Studies on novel findings of this study

In comparison to previous studies there are some new findings in this study. The novel findings, fear of boundary violations, sadness and intolerance to uncertainty, could be examined specifically in the future to determine their confidence.

7.2.5. Studies on gender-related tendencies about self disclosure

Although there are some researches that studies gender differences on willingness to self disclosure (Stokes et al., 1980; Newmann, 1987), there are no studies with a sample of psychotherapists. In this study, all of the male therapists that was proposed to volunteer, declined to participate in the study. This fact evokes curiosity and can be a subject of further research.

7.2.6. Studies on further implications for supervisors and trainers

The behaviors and techniques in training and supervision that help inexperienced therapists to overcome these experiences of difficulties is a broad research area. As a solution to the problems inexperienced therapists have overcoming these difficulties and to support them to maintain their motivation towards the profession, self-disclosure of the experienced therapists and supervisors is recommended. Further solutions and recommendations should be investigated in future research to improve the wellbeing of this profession.

CONCLUSION

This study's purpose was to explore the experiences of inexperienced and experienced psychotherapists in difficult clinical moments and to compare the similarities and differences. This study aspired to help psychotherapists, especially inexperienced therapists, understand the meaning of their experiences, encourage them to seek help and guidance when they need and help improve their clinical practice and their motivation about being a psychotherapist. This study also aims to help experienced therapists, trainers and supervisors improve psychotherapy training programs and supervisions in a way to provide more support to inexperienced psychotherapists experiencing difficulties.

The purpose of this study is discussed in the Introduction chapter. Also in the Introduction chapter, the researcher's personal history and motivation about this study is reflected in the Personal Background section and the gap in the research is discussed in the Gap in the Research Area section.

In the Literature Review chapter, psychoanalytic and existential theories on therapists' experiences in difficult clinical moments, countertransferencial feelings, noncountertransferencial feelings and therapists' feelings in the relationship with their clients are discussed.

In the Methodology chapter, information about the participants, procedure, data analysis and the study's trustworthiness is given.

In the Results chapter, the findings of the study is reported. According to the analysis of the data, six main themes and seven subthemes were found. Three main themes were found to be similar and three main themes were found to differentiate between the inexperienced and the experienced therapists.

In the Discussion chapter, each result is discussed in the light of the theoretical framework and empirical researches.

It has been found that both inexperienced and experienced therapists experience fear of boundary violations, avoidance of revealing feelings and sadness during difficult clinical moments:

- The experience of fear of boundary violations emerges in the connectedness of the therapeutic dyad especially with clients who have separation-individuation issues. As a result, therapists end up experiencing countertransferencial feelings of terror of engulfment from the attempts of merger of the client, likewise in the situations of withdrawal of the client, they may feel a desire to merge and fear engulfing the client.
- The experience of avoidance of revealing feelings emerges to maintain the therapeutic frame, moreover in fear of making a boundary violation themselves or letting the client make a boundary violation. Therapists avoid revealing feelings to take a distance from clients, because being open and disclosing, "being oneself" in the room, being in the connectedness of the therapeutic dyad, makes the relationship feel too real and therapists feel vulnerable in this realness.
- The feelings of sadness experienced in the difficult clinical moments emerge as a result of empathic attunement and authentic engagement. Sharing difficult feelings is a fundamental part of being in a relationship and it is what makes the healing possible. The therapist's toleration and processing of these feelings helps the client get in touch with her/his own feelings and tolerate them more easily.

It has been found that while inexperienced therapists feel incompetence, anger and intolerance to uncertainty, experienced therapists reported that they have overcome these feelings as they gained experience:

- The feeling of incompetence the inexperienced therapists experience in the difficult clinical moment emerges from their constant focus on their inner psychological state, their self-dynamics and how they might be seen from the perspective of the client. The experienced therapists overcome these feelings by accepting and embracing their own limits as a person and a therapist, accepting the client's limits, accepting fact that not every client can be healed, that every client has a capacity to be held and by keeping the curiosity for the

client's inner world alive and focusing on it, instead of focusing on their own ongoing internal state of feelings.

- The feelings of anger the inexperienced therapists experience in the difficult moments emerge as a countertransferencial reaction to extreme needs of the clients. The experienced therapists report that they became more able to manage their anger and keep it latent as they gained experience.
- The intolerance to uncertainty the inexperienced therapists experience in the difficult clinical moments emerges as a result of trying to control the uncertainties that life brings and uncertainties in sessions, which is impossible. Experienced therapists report that they embrace the uncertainties that life brings and that they go with the flow instead of trying to control it.

In the Recommendations chapter, the recommendations to experienced therapists, trainers and supervisors is given. It has been found that, the difficulty disclosures made by experienced therapists and supervisors, normalize the difficulty experiences and help trainees and inexperienced therapists overcome the shame that emerges from experiencing difficult clinical moments and help them share these more easily. The disclosures that experienced therapists make help inexperienced therapists feel like they are not alone, the feelings that they experience are normal and there is nothing wrong with being vulnerable.
Finally in the last chapter, the limitations of the study and the recommendation for the future research is given.

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10. ANNEXES

Annex 1: Informed Consent Form

Gönüllü Onam Formu

Sayın Katılımcı;

Bu çalışma, Doç. Dr. Ayten Zara'nın danışmanlığında, İstanbul Bilgi Üniversitesi Klinik Psikoloji yüksek lisans öğrencisi Gizem Güroy Çimen tarafından, psikoterapistlerin, klinik ortamda yaşadıkları zor anlara dair deneyimlerini daha iyi anlamak amacıyla yürütülmektedir. Bu amaçla, eğer katılmayı kabul ederseniz sizinle yaklaşık 1-1.5 saatlik bir görüşme yapılacak ve bu görüşme daha sonra yazıya aktarılmak üzere sesli kayıt altına alınacaktır. Çalışmaya katılarak, psikoterapistlerin, psikoterapiye dair yaşadıkları zor deneyimlerin daha iyi anlaşılmasına ve bu alandaki bilimsel literatüre katkı sağlamış olacaksınız.

Bu çalışma kapsamında verecek olduğunuz tüm cevaplar tamamen gizli kalacaktır. Çalışmaya katılım gönüllülük esasına dayanmaktadır. Verdiğiniz cevaplar sadece araştırmacılar tarafından değerlendirilecektir. Yazıya aktarıldıktan sonra bu kayıtlar silinecektir.

Çalışmada anlatacağınız algı ve deneyimleriniz doğrultusunda bir takım olumsuz duygular hissedebilirsiniz, fakat bunların görüşme sonrasında uzun süre devam etmesi veya yaşamınızda bir olumsuzluğa yol açması beklenmemektedir. Olumsuz duygular görüşmeden sonra devam ettiği takdirde, ihtiyacınız doğrultusunda profesyonel destek alabileceğiniz kişi ve kurumlara yönlendirme yapılacaktır. Katılım sırasında herhangi bir nedenden ötürü kendinizi rahatsız hissederseniz, soruları cevaplamayı istediğiniz anda bırakmakta serbestsiniz.

Bu formu imzalayarak araştırmaya katılım için onay vermiş olacaksınız. Bununla birlikte kimlik bilgileriniz çalışmanın herhangi bir aşamasında açıkça kullanılmayacaktır. Görüşmede verdiğiniz cevaplar ve araştırma süresince işitsel cihaz kullanılarak edinilen her türlü bilgi, yalnızca bu araştırma kapsamında

kullanılacak, başka hiçbir amaç için kullanılmayacaktır. Araştırma sonlandığında tüm kayıtlar silinecektir.

Çalışma hakkında daha fazla bilgi almak için Klinik Psikolog Ferhat Jak İçöz (ferhatjakicöz@gmail.com) veya Uzman Psikolog Gizem Güroy Çimen (gizemguroy@gmail.com) ile iletişim kurabilirsiniz.

Bu bilgilendirilmiş onam belgesini okudum ve anladım. İstediğim zaman bu araştırmadan çekilebileceğimi biliyorum. Bu araştırmaya katılmayı kabul ediyor ve bu onay belgesini kendi hür irademle imzalıyorum.

Katılımcı Adı Soyadı:		*Tarih ve İmza:*
Telefon:		

Araştırmacı Adı Soyadı:		*Tarih ve İmza:*
Telefon:		

Annex 2: Interview Questions

Görüşmedeki sorular, aşağıdaki konuları anlamak adına sorulmuştur:

1. Katılımcı için "psikoterapide yaşanan zor anlar" ne anlama gelmektedir?
2. Katılımcının psikoterapide yaşadığı zor anlara dair deneyimleri nelerdir?
3. Katılımcının, psikoterapide yaşadığı zor anlardan sonra kendine dair hisleri ve deneyimi nasıldır?
4. Psikoterapide yaşanan zor anların terapist-danışan ilişkisine ve terapötik sürece etkileri nelerdir?
5. Katılımcının, psikoterapide yaşadığı zor anların ardından terapist olmaya dair hisleri ve deneyimi nasıldır?
6. Katılımcının, psikoterapide yaşadığı zor anların ardından ihtiyaçları nelerdir?

Yukarıdaki konulara dair örnek sorular aşağıda yer almaktadır:

1. Psikoterapide yaşadığınız zor anlar nelerdir? Biraz bahseder misiniz?
2. Bu zor anları nasıl deneyimliyor/anlamlandırıyorsunuz?
3. Bu zor anların neden kaynaklandığını düşünüyorsunuz?
4. Bu deneyimden sonra kendinize dair neler hissettiniz?
5. Bu deneyimden sonra psikoterapist kimliğinize dair neler hissettiniz?
6. Bu deneyimden sonra mesleğinize dair neler hissettiniz?
7. Bu deneyimden sonra danışanınızla ilgili neler hissettiniz?
8. Bu deneyimden sonra danışanınızın neler hissettiğini düşündünüz?
9. Bu deneyimin terapötik sürece nasıl bir etkisi olduğunu düşünüyorsunuz?
10. Bu deneyimi meslektaşlarınızla paylaştınız mı? Paylaşmak istediniz mi?
11. Eğer paylaştıysanız, bu size nasıl hissettirdi?
12. Meslektaşlarınızın bu paylaşımdan sonra size dair neler düşündüğünü/hissettiğini düşündünüz?
13. Bu deneyimi süpervizörünüzle paylaştınız mı? Paylaşmak istediniz mi?
14. Eğer paylaştıysanız bu size nasıl hissettirdi?

15. Süpervizörünüzün bu paylaşımdan sonra size dair neler düşündüğünü/hissettiğini düşündünüz?
16. Psikoterapide yaşadığınız zor anlardan sonra nelere ihtiyaç duydunuz?
17. Paylaştığınız meslektaşlarınızdan/süpervizörünüzden beklentiniz neydi?
18. Bu süreçte ihtiyaç duyduklarınızı aldığınızı düşünüyor musunuz?

ETİK KURUL DEĞERLENDİRME SONUCU/RESULT OF EVALUATION BY THE ETHICS COMMITTEE

(Bu bölüm İstanbul Bilgi Üniversitesi İnsan Araştırmaları Etik Kurul tarafından doldurulacaktır /This section to be completed by the Committee on Ethics in research on Humans)

Başvuru Sahibi / Applicant: Gizem Güroy

Proje Başlığı / Project Title: Psychotherapits' Experience of Different Clinical Movements: A Comparative Study between Inexperinces and Experinces Psychotherapists

Proje No. / Project Number: 2019-20024-23

1.	Herhangi bir değişikliğe gerek yoktur / There is no need for revision	XX
2.	Ret/ Application Rejected Reddin gerekçesi / Reason for Rejection	

Değerlendirme Tarihi / Date of Evaluation: 12 Şubat 2019

Kurul Başkanı / Committee Chair

Doç. Dr. Itır Erhart

Üye / Committee Member

Prof. Dr. Aslı Tunç

Üye / Committee Member

Prof. Dr. Turgut Tarhanlı

Üye / Committee Member

Prof. Dr. Hale Bolak Boratav

Üye / Committee Member

Prof. Dr. Koray Akay